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GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

January.

Sat. 11. 1st XV. v. U.C.S. Old Boys (Home).
2nd XV. v. Old Charltonians (Away).
1st XI. v. Beckenham (Home).
2nd XI. v. Beckenham A (Away).

Mon. 13. Second part of Conjoint D.P.H. begins.

Tues. 14. Final Conjoint begins.

Wed. 15. Physical Society's Meeting, at 8 p.m.
1st XI. v. Casuals (Home).

Thur. 16. Mr. Lane's and Sir Cooper Perry's Take-in commences. (Messrs. Walker and Ticehurst.)

Sat. 18. 1st XV. v. Lennox (Away).
2nd XV. v. London Welsh A (Away).
1st XI. v. Alleyn (Away).
2nd XI. v. Sidcup A (Home).
Debating Society's Meeting, at 8 p.m.

Mon. 20. Preliminary Scientific (Part I.) and Intermediate M.B. Examinations commence.

Thur. 23. Mr. Dunn's and Dr. Shaw's Take-in begins. (Messrs. Smalley and Goodhart,)

Passim.

AGAIN we have settled down into our accustomed calm after one of the most successful Christmas weeks in our annals. Well have the traditions of Christmas at Guy's been maintained. From the advent of the Niggers to the flickering of the last flame of the bonfire, all has gone with a swing. Both students and nurses have worked with an unselfish zeal, assisted by the many kind and talented friends who have been within our walls, and every patient—from old daddy, who has lovingly fondled his long-cherished pipe and baccy, to the veriest tot whose infantile cries of delight have greeted Father Christmas' advent—has, we are certain, appreciated their efforts to the utmost.

THIS year, owing to the generosity of Sir Alfred Fripp, we have been able to give a second Out-patients' Tea on the 26th. It has always seemed a pathetic sight to us to see the pinched faces peering through the gate of those children who have been unable to be admitted to what, to them, is the red-letter day of their lives. To Sir Alfred, who interested himself on their behalf, then must 580 more of them be grateful. The total number of children entertained this year was roughly 1,200, and Sister Out-patients', Messrs. Rippmann and Goodhart, and the many willing helpers, are all to be congratulated on the excellent manner in which the whole proceedings have been carried out.

OUR show of Concert posters this year was most striking, and one heard laudatory comments on all sides. To Mr. Wingent, Miss Vandermin, and the other artists, we are all indebted. The clever frontispiece to the Residents' Theatricals Programme, designed and drawn by Mr. R. W. Wingent, came in for a considerable amount of praise. This gentleman is ever ready with his talented brush to come to the assistance of all, and we are, we believe, voicing a common sentiment when we say that his labours are appreciated to the utmost.

ANOTHER gentleman to whom a great share of the success of the Christmas festivities, especially the Niggers, is due, is Mr. A. Alcock. Mr. Alcock took his departure from us on the 22nd December, and is now acting as ship's surgeon in the West Indies. He took with him the best wishes of all for a happy and successful career.

IN the Colonnade may be seen copies of the photographs taken this Christmas. The price is 1s. each unmounted. The proceeds are to be devoted as follows: the profit derived from the sale of the Nigger group towards the Million Shilling Fund, and that from the Residents' Theatrical group to the Miller Fund. Lists may be found in the porter's lodge at the College, or names may be given to Mr. H. J. Henderson.

WE have received notice of the inaugural meeting of a new medical club, formed on what we believe to be somewhat original lines. We refer to the Weymouth and District Medical Club. The members consist of all medicos in actual practice in the district, and they meet monthly. The object of the club is "for the promotion of social intercourse and mutual support in any difficulties which may arise affecting the profession or individual members." This idea is an excellent one, and one which, if imitated in the provinces generally, would, we feel sure, be conducive not only to the smoothing away of many minor difficulties, but also to the fostering of that *esprit de corps* amongst fellow practitioners which tends towards unity.

ON another page will be found Tables showing the distribution of patients amongst the different Convalescent Homes in connection with the hospital, and also the amounts found in the various collecting boxes, together with special donations. The figures for the preceding year are appended for the purpose of comparison. It will be noted that the total amount received from these channels is £106 9s. 9d. in excess of the previous year. As an important source of revenue, these boxes, etc., may, perhaps, be but a trivial consideration, but to us the "human" side of them has always appealed. They reflect a trait which, nowadays, is all too rare—gratitude.

We are pleased to acknowledge the receipt of the sum of £28 17s. 0d., from the Nurses attached to the Guy's Hospital Institute, towards the support of a Cot during the present year.

IN reference to the much-criticised regulations issued by the Indian Council in respect to the notification of fees acceptable from private patients, we have received some cuttings from the *Pioneer*, one of the leading Indian journals. We are pleased to see that they endorse the sentiments expressed by all the leading medical journals, and openly state that they are in entire sympathy with the Service. The regulation referred to states that, "before demanding and accepting from any Indian gentleman, or gentleman of high position in a native State, any fee for professional services rendered, the medical officer shall obtain the permission of the Director-General." Such permission is only necessary when the total amount exceeds, for one month, Rs. 160. This restriction implies one of two things, either that the Indian gentleman is incapable of protecting his own interests, or that the integrity of the Service as a whole is questioned. This latter reflection is one which the profession generally must resent, and we trust that the department will see the error of its way and quickly remove this bar sinister.

HERR G. HAULTENHOFF resumes his German classes for medical men and students on the 13th prox. at 9 p.m. The classes are to be held twice a week, Wednesdays and Saturdays, at 9 p.m., and are specially directed for the reading of medical books and general conversation. The fee for a course of twelve weeks is £3 3s. Further particulars may be had on application to the Dean.

THE going-off dinner was held on the 26th December, and proved to be the enjoyable and hilarious function it usually is. Mr. Wragg, the off-going President, announced that the

President for the ensuing term was Mr. Sep. Cooper, and the Vice-President Mr. Macallister, an announcement which was justly popular. The customary speeches were made, the customary toasts drank, and the evening ended with ringing cheers for everyone and "Auld Lang Syne."

WE would like to draw our readers' attention to the Miller Fund, which is not receiving the support which one would desire. The old man, for so long a faithful servant of the Clubs' Union, is finding the winter very trying, and any donation, no matter how small, will be gratefully accepted. Mr. S. Croucher will be pleased to receive contributions, which will be acknowledged in these columns.

MESSRS. ASH & Co. have forwarded the sum of £22 as the amount resulting from the sale of the elegant Hospital Christmas Cards, so admired by all, to the Hospital Fund. This firm prepared and published these cards at their own expense, so that this sum must be regarded as a direct contribution. Whenever any question regarding a charity connected with our institution is in the air, Messrs. Ash & Co. are always to the fore. To them, then, and also to Miss Smith, of the Matron's office, and Mr. Mills, the Librarian, who so kindly attended to the sale of the cards, our best thanks are due.

A KINDLY incident, which is always most appreciated, is Lady Bective's practical interest in those merry black men who so nobly and effectively try to amuse our inmates on Christmas Day—the Niggers. Her Xmas gift to each member is merely another demonstration of that benevolent interest she has always displayed in the affairs of our hospital.

THE Residents' Annual Dance is to be held on February 7th prox., at the Whitehall Rooms, Hotel Metropole, W.C. Mrs. Cosmo Bonsor has kindly consented to act as hostess, and is taking a lively interest in ensuring the success of the function. We trust that the change of venue will tend to popularise this dance, which is one of the few occasions of a social kind where we can all meet. Some men are apt to think, because this is the "Residents'" Dance, they are not welcome; but this is not so. Remember it is a hospital dance, given by the Residents, and that as such it should be supported by all. The cost of the tickets is: Gentleman's, 12s. 6d.; Lady's, 10s. 6d.; this includes supper. They may be obtained on application from any of the Residents. We trust that there will be a big assembly, and that a precedent may be set up, so that the Annual Dance may take its place, with those of some of the other hospitals, as one of the minor social events of the year.

A FEATURE which is being reproduced in this number of the GAZETTE (the first of Volume XXII.) is a summary of some of the interesting cases in the medical wards. We trust that they will be of some guidance to any old Guy's men who are revisiting us, and those students who, through stress of other duties, might miss cases which are instructive and, at present, close at hand. For the lists and short notes we are indebted to the clinical assistants, Messrs. R. P. Roberts and Stott. In the next number a list of surgical cases will be given.

THE Annual Dinner of the Guy's Hospital London University Club will be held at the Trocadero on Friday, January 31st, at 7.30. The club, which was founded in 1889, has at present about 150 members. Any Guy's men, past or present, who are graduates or undergraduates of the University of London, are eligible for membership. The Secretaries, Messrs. Philip Turner and K. H. Digby, will be pleased to supply any further information about the club and to receive the names of any new members.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated.*

The Residents' Theatricals Souvenir.

OWING to the great interest displayed, and many inquiries on all sides, it has been decided to publish the "book" of the Residents' recent Farce, "Autocure," in Souvenir form. Messrs. H. O. Brookhouse and Harold Chapple have kindly consented to re-write the play, introducing "business," etc., whilst Mr. R. M. Wingent has undertaken to provide the illustrations.

The advance copy, which we have seen, is an elegant production, which should appeal not only to men directly interested in the Farce, but to all the men (and nurses, too), and also to old Guy's men. Remember, the Farce is a topical one, and many old familiar phases will be brought to mind.

The Souvenir, which is to be published **by subscription only**, is to cost 2s. 6d.

All profits are to be given to the Million Shilling Fund.

The inset in this number is a subscription form which should be filled in, and, with the necessary enclosure, returned **as soon as possible** to—

THE EDITOR,
GUY'S HOSPITAL GAZETTE,
BORO', S.E.

We trust that this Souvenir, which, apart from its charitable aspect, is excellent value for the money, will receive the support of all Guy's men and nurses.

Pass List.

UNIVERSITY OF CAMBRIDGE, November, 1907.—Degree of M.D.—H. C. Cameron, M.A., M.B., B.C. (John). Degree of M.C.—E. W. Sheaf, M.A., M.B., B.C. (Downing). Third Examination for Medical and Surgical Degree.—Part II.—Surgery, Midwifery, and Medicine.—H. B. Carlyll (John's), R. G. Chase (Trinity), E. B. Hinde (Emmanuel), B. H. Palmer (Pembroke), J. H. Ryffel (Peterhouse).

UNIVERSITY OF OXFORD.—Pathology.—Mr. N. Flower (Exeter College). Forensic Medicine and Public Health.—Mr. N. Flower (Exeter College), Mr. D. B. Todd (Lincoln College). Medicine, Midwifery, and Surgery.—Mr. C. G. Douglas (Magdalen College).

Christmas Week.

(Continued.)

The Hicks Concert.—Charity and Luke.

Once again Miss Ellaline Terris and Mr. Seymour Hicks kindly brought down a talented troupe of players, and gave us what was a most enjoyable afternoon. The concert was held in the Physiological Lecture Theatre, on Monday, December 30th.

Mrs. Seymour Hicks sang a charming ditty of her own and the "Dumpty Tumpty" song. During the progress of the latter an unrehearsed little episode caused the audience much amusement; little Betty Hicks wandered on from the wings and stood by her mother, who then sang to her. Mr. Hicks, as vivacious as ever, gave us in his inimitable way, "Some do it this way," and several other song sketches. Miss Barbara Deane sang "The songs my mother sang to me," and later the "Echo" song from the "Gay Gordons." Amongst the other performers were Miss Kate Butler, Miss Delmar, and Messrs. Clency, Crampton, Tours, and Anderson. Mr. L. Deane stage managed the concert.

At the conclusion Mr. Golding-Bird, in a witty speech, thanked Mr. and Mrs. Hicks and the performers for their kindness and trouble.

Mr. Seymour Hicks, in replying, emphasised the fact that they derived much pleasure from it, and ended what was indeed a pleasant afternoon for not only the hundred or more patients grouped around, both on the stage and in the auditorium, but also to the many nurses and students present, by stating that a certain section of the seats, for the next Wednesday afternoon's matinée of the "Gay Gordons" would be put aside for Guy's Nurses.

The Residents' Theatricals.

The Residents' Theatricals (reported in our last issue) were repeated on the evenings of Friday 27th, and Saturday 28th ultimo.

Miss Olive Davies' and Mr. Dryland's humorous and admirably acted dialogue, "Two on a 'Bus," met with the same enthusiastic reception as on the first evening.

On Friday, Madame Guy d'Hardelot, the well-known song composer, and Miss Julia Caroli, brought down a concert party. Appended is the programme of the Friday's performance :—

Piano Solo, Valse (Chopin), Miss Brigstock; Song, "Saper Vorriste" (Verdi), Miss Julia Caroli; Song, "You and Love" (Guy d'Hardelot), Signor Manrico Bacci (accompanied by composer); Song, "Nobil Signor" (Meyerbeer), Madame Leila Denza; Song, "Thy Songs" (Guy d'Hardelot), Miss Caroli (accompanied by composer); Song, "You" (L. Denza), Madame Denza (accompanied by Signor L. Denza); Song, "Because" (Guy d'Hardelot), Signor Bacci; Humorous Songs, Selected, Mr. Stanley Hazell.

Needless to say, every item was excellent. Miss Caroli, with her beautiful soprano, charm of manner, and

clearness of diction, carried the house by storm. She generously responded with an encore.

Madame Guy d'Hardelot herself accompanied Signor Bacci in the next number. His good voice, exquisitely trained, is heard to advantage in these light ballads. Madame Denza, the popular contralto, sang the "Nobile Signor" solo from "The Huguenots," whilst her husband, Signor Denza, accompanied—an effective combination.

In the second half of the programme Miss Caroli (accompanied by the composer) sang one of Guy d'Hardelot's later songs; her upper register, so clear, so true, was a revelation to the delighted audience. Perhaps one of the most popular items was Signor Bacci's rendering of the ever popular "Because," the audience vociferously demanding an encore. The full beauty of Signor Denza's ballad, "You," was brought out by his wife's cultured contralto, her rich full voice being assisted by the composer's accompanying, the whole being a highly enjoyable performance. Mr. Stanley Hazell concluded the concert portion of the programme by singing some of those delightful little "nonsense" songs.

On the Saturday evening the programme opened with a Pianoforte Solo by Miss Brigstock. She played one of Liszt's Melodies.

Miss Caroli again sang, and her reception was worthy of her magnificent efforts.

Mr. Harold Chapple sang "An Old Song" (Nevin). We congratulate him on his performance. How, through the stress of the preceding strenuous days, he managed to maintain such good form is a mystery.

Mr. Ray Edridge recited again Jerome K. Jerome's "Telephone," and in response to an encore gave a most excellent rendering of Kipling's "Chant Pagan."

The performance concluded with a Duet, "The Keys of Heaven," rendered with the utmost charm by Miss Caroli and Signor Bacci. The *naïveté* and grace with which this was sung won the hearts of the audience, who demanded an encore. They then sang "No, Sir!" The appreciation with which these duets were received must have been gratifying to both the talented performers. Mr. Horace Friedlander and Miss Brigstock were the accompanists for the evening.

The Farce itself, on both Friday and Saturday evenings, went with a merry swing from beginning to end. Mr. Chapple's efforts and quips were hailed with great delight; Mr. Rippmann's clever impersonation seemed more realistic than ever, whilst Mr. Dryland's good work was the source of much applause.

To this last player and to Mr. Ray Edridge the thanks of all are due for the care and trouble they have expended in producing this year's "performance." Mr. Dryland has been indefatigable; nothing has been too much trouble. As is his wont, he has entered upon his manifold duties as stage manager with a zest which has been the admiration of all. Mr. Edridge, though he is no longer amongst us, has been untiring in his efforts to make things go. His ripe experience and his genius for organization made themselves felt the moment he appeared.

Queen Victoria.

On Friday a concert was held in Queen Victoria. The performers, Misses Royle, Chevalier, Davies, and Gable, and Messrs. Brook, Endean, and Davies, were aided by a ventriloquist, Mr. Pile, who delighted one and all by his clever performance. His imitations of the farmyard, sawing wood, etc., were clever in the extreme. Miss Royle played two pianoforte solos. Miss Muriel Chevalier recited with great charm, her rendering of "Lasca"—essentially a male performer's piece—was of a very high order. The Misses Davies sang "If I were a Tiny Bird" as a duet, which was justly popular. Miss Gable and Miss Sumner also sang, both displaying voices of no little beauty. Messrs. Brook, Endean, and L. G. Davies contributed vocal numbers.

Mary.

This concert was held on Friday, December 27th, and for a very pleasant afternoon the thanks of all have to be tendered to Mr. Bellew, of His Majesty's Theatre, who very kindly brought down a small band of able performers. Messrs. Huntly, Murphy, and Henry, rendered songs, sentimental and otherwise (chiefly otherwise), "Potted Poems," sung by Mr. Huntly, being particularly popular. With the company were four of the children from the Prince of Wales' Theatre, who entered into the spirit of the entertainment with great zest. Mr. Bellew and his friends were unable to arrive till 5.30 on account of matinée performance, so the first half of the programme was furnished by friends of Sister Mary and some local talent. Miss Whittingham sang several songs most delightfully, while Miss Shadwell recited "Seein' things o' nights," and "The Courtship of Saunders McGlauchin" with much feeling. Mr. Whittingham sang of a game of "Diabolo," and of a coloured gentleman who created a stir at the seaside. Messrs. Endean and Nutman also sang.

Addison.

A short but enjoyable concert was held in the above Ward on 27th December.

Piano solos were played by Nurse Murphy and Mr. M. E. Ball. Vocal numbers were contributed by Miss Bramley Taylor, and Messrs. Catto, Nutman, D. Mitchell, and Endean. Sister Dorothy delighted all by two violin solos.

Martha.

The Christmas Tree in Martha passed off with its usual jollity. The happy band of kiddies received from the hands of Father Christmas (Mr. E. Wragg) their several gifts with every show of juvenile delight.

Dorcas.

In Dorcas an enjoyable afternoon was spent on the Friday, whilst in LAZARUS, at the same time, a very clever ventriloquial entertainment took place.

Charity.

The Charity Christmas Tree distribution was held on he 28th, at 3.30. Amongst those present were Lady Bective, the Matron, and Mr. and Mrs. Golding-Bird. Mr. Sep. Cooper made an excellent Father Christmas. Concerts were also held in the EYE WARDS, CORNELIUS and ESTHER on the 28th. Unfortunately the Lazarus Concert clashed with the Luke and Charity (Mr. Seymour Hicks') Concert. On Tuesday, 31st, in the afternoon, Mr. Compton Smith, of the Lyric Theatre, brought down a party which gave us an excellent programme in PATIENCE ward.

Astley Cooper.

As usual, this concert, the last of our Christmas fêtes, was held on December 31st, at 7 p.m. There was a large attendance, and the audience enjoyed an excellent programme. Messrs. Palmer, Davies, Trethowan, Dryland, Millins, Kidd, Chapple and Endean contributed numbers, whilst Mr. F. Haskoll delighted all with his clever singing of "The Lily of Laguna," "Philosophy," "Egypt," etc. The proceedings concluded with "Auld Lang Syne" and hearty cheers for Sister Astley Cooper, Mr. Wragg, and the other off-going Residents.

Nurses' Entertainment.

The annual entertainment given by the Nurses took place on Monday evening, December 30th, in the Nurses' Home. The large dining hall served as a concert room, whilst in the sitting room, most tastefully decorated, a buffet supper was served.

The concert opened with a pianoforte solo, a selection from "Lucrezia," in which Nurse Murphy showed skill and a considerable technique.

Nurse Moxon and Nurse Mawson were then heard to advantage in a duet. In the next number Nurse Ball evidently had the play of last year in mind when she wrote the topical verses which she so ably recited—truly a Roland for our Oliver.

Then followed the Golliwog Troupe, consisting of Nurses Farrow, Baker, Bell, Corbrahly, Hunter, E. C. Jones, Mather, McMorland, Pearce, and Short, who, after the style of the "Ten Little Nigger Boys," gave us some more clever verses. We congratulate them on their make-up, and also Sister Surgery, who, we believe, was in a great degree responsible for their excellence.

The second part of the programme opened with a pianoforte solo by Nurse Bingham, then came a Welsh song (in costume) by Nurse Lewis, her well-trained voice being much appreciated. Sister Dorothy was encored for her violin solo, giving us the ever-popular Cavalleria "Intermezzo."

Undoubtedly the plum of the evening were two dances, a "Gavotte de Bal" and "Frolique," danced by Sisters Mary and Theatre, and Nurses O. Clifford, Kreutze, Lorraine, Lumholtz, Sayer, and Vine. Their pretty Empire frocks gave an additional old-time grace to their highly artistic performance.

After the concert the hall was cleared, and, by the further courtesy of the Matron, dancing was indulged in. Several members of the Staff were present; amongst others was noticed Mr. Arbuthnot Lane, who was accompanied by Mrs. and Miss Lane.

A party of ladies and gentlemen, consisting of about fifteen members, and a string quartette, organized by Mr. Oram, have been greatly appreciated in the wards this Christmas, their vocal and instrumental selections from the Savoy comic operas being much enjoyed. They visited most of the wards in turn, and the hearty welcome which they received must have demonstrated that their fame had preceded them.

Some Observations on Arterial Blood-Pressure in Health and Disease

BY H. C. MANN, M.D., M.R.C.P. (LOND.).

I.

THERE appeared in the *Lancet* of September 8th, 1906, a paper from the pen of Dr. H. Starling, in which evidence was brought forward to show that in ordinary cases of cardiac failure, resulting from valvular disease, the "systolic blood-pressure," as registered by the manometer, was invariably higher than is normal in healthy individuals. In support of such opinion, reference was made to the enormous reserve power of the cardiac mechanism as displayed by the classical experiment of Cohnheim with the aortic ligature, where the arterial blood-pressure was found to rise in the peripheral vessels in spite of the increasing resistance offered in the first part of the aorta to the ventricular output.

So many clinical facts, however, of every-day occurrence, are explained on the assumption that, in cases of "failing heart," there is a steady fall in the arterial blood-pressure, that we have considered the subject deserving of further observations.

Attention was first directed to an estimation of the arterial blood-pressure, and its daily variations in healthy individuals, as a result of the ordinary incidents and accidents of every-day life.

The instrument used for making these observations was Martin's modification of the Riva-Rocci manometer. It consists simply of a manometer, connected by means of a stout rubber tube with a collapsible rubber bag, oblong in shape, which is fastened to the arm of the patient by means of two straps. A "T"

piece, provided with an escape valve, connects the tubing with a simple air-pump, so that the bag can be filled with air under pressure, or emptied, at will. The bag is made of two thicknesses of gutta-percha—the inner thin, which is in contact with the arm, is very elastic; the outer is non-distensible.

If a normal individual be taken, and if the bag, previously strapped to the arm, be gradually distended with air, it will be found that at a certain level of mercurial pressure, which varies in different individuals, the radial pulse is lost. This reading will give the maximum systolic pressure in millimetres of mercury. If, now, the air in the bag be allowed to escape slowly, the observer will notice that, with the falling pressure, the pulse waves will reappear, quite suddenly, at a reading slightly lower on the scale than that which he previously registered, but which latter reading is constant. This is the mean pressure of the ventricular systole in the brachial artery. He will, however, notice that, *at this reading*, the *full* pulse wave is not obtained at the wrist, though every beat can be felt. As, however, a further amount of air is allowed to escape from the bag, there will come a time when he will appreciate a sudden change in the character of the wave impinging against the finger, the full characteristics of the individual's pulse will be felt with the normal excursion of the arterial wall. This third reading corresponds to the mean diastolic pressure in the vessel.

The difference between these two latter readings, the mean systolic and the mean diastolic pressure, as also the actual value of them, varies much at different ages, in different individuals, in health and disease, with rest and exercise. Apparently, in most healthy individuals, the difference between the two readings measures about thirty millimetres of mercury. The variations which occur as the result of disease will be mentioned hereafter. The observer will not, however, fail to notice that, even in health, at different hours of the day, he will obtain different readings, and, at the end of this paper, figures are given recording a number of observations made upon different individuals, apparently quite healthy, who were leading useful and active lives. It may here be stated that there seems to be no doubt that the blood-pressure, as registered by this manometer in the manner above described, is *lowest* immediately on waking, before rising or moving, in the morning, and rises during the day until about six o'clock. This rise is noticed not only in the case of the mean diastolic pressure, but also in the case of the mean systolic pressure. The rise, however, of the former is greater than the rise of the latter. Later in the evening, both readings of blood-pressure will be found to be falling again. As a result of vigorous exercise, there is a marked rise noticed in the value of both systolic and diastolic pressure. The exercise taken, swimming, running, playing "squash" racquets, physical drill, produced greater or lesser variations according to the time of day at which it was taken, and according to the "condition" of the individual, that is to say, whether "trained" or "untrained." For instance, in the early morning, immediately on rising, the effect of exercise stimulates the heart to rather excitable action, so that it beats very vigorously, possibly more vigorously than is necessary. And it will also be noticed that, as in cases of failing heart hereafter mentioned, some of the ventricular beats are much more forcible than others, so that a maximum systolic reading is obtained, possibly some 20 mm. above the mean systolic pressure, and only occurring, perhaps, once in twelve or twenty beats. Later in the day this tendency to excitable action is by no means so marked; possibly the vaso-motor mechanism is more alive and ready to appreciate changes occurring in the action of the central cardiac mechanism as the result of environment. The observer will also notice this tendency to excitable action—and therefore to abnormal increase in blood-pressure—in individuals who are totally "untrained" or imperfectly "trained." We are inclined to think that it will also be found in individuals who are "overtrained," that is to say, "stale." It will be noticed that there is a retardation or slowness exhibited in the rise of the mean diastolic pressure in such people after any given amount of exercise, although a maximum systolic reading has appeared which has disturbed the normal relationship between systolic and diastolic pressure.

Another series of observations were taken in the cases of healthy people who had taken vigorous exercise shortly after taking a substantial meal, that is to say, while the splanchnic area was in a state of general vaso-dilatation. The diastolic pressure remained low—in one case it was lower than normal; the mean systolic pressure was considerably higher than normal, but the wave coming through at this reading was small, and it was evident that the pressure recorded only existed for a very short portion of the cardiac systole. Irregular beats were also felt, occurring at considerable intervals, and due apparently to excitable cardiac action (max. syst. press.).

This tendency, however, to excitable action (the rhythm remaining regular) is not shown in the case of individuals who are in "training." In such people the mean systolic pressure never rises to so great an extent, but the diastolic pressure rises early and remains above normal for some time. Irregular maximum systolic readings are absent. The phenomenon known as "second-wind," which occurs in the case of a runner who is imperfectly trained, is associated apparently with the facts detailed above. While the man is distressed, and *before* he obtained relief with the advent of "second-wind," mean diastolic pressure remains low, recovering and rising with the disappearance of his distress, the mean systolic pressure having risen earlier and remained constant.

We have noticed transient rises in the mean systolic pressure to occur after such incidents as vomiting, coughing, straining at stool; the increase in pressure varied with the degree of trouble, but it was of short duration.

From a consideration of the facts recorded above, it will be obvious that, even in healthy individuals, considerable variation in arterial blood-pressure occurs, both as regards the actual value of systolic and diastolic pressure, and as regards the relation which these two values bear to one another.

BLOOD-PRESSURE READINGS FROM HEALTHY PEOPLE.

TABLE I.—*Ten readings taken morning* (7 a.m.), and evening (5 p.m.), on ten successive days. Male. Age 28. Figures refer to millimetres of mercury.

	Morning.		Evening.	
	Diastolic.	Systolic.	Diastolic.	Systolic.
1.	94	120	110	130
2.	90	120	106	126
3.	92	122	110	140
4.	94	120	108	136
5.	94	120	112	140
6.	96	122	112	138
7.	94	120	108	136
8.	92	120	110	136
9.	92	120	110	138
10.	94	120	110	140

The morning readings were taken before rising, while the individual was in bed. The evening readings, in each case, after a moderate and variable amount of exercise. The actual value of the reading varies in different individuals. We have found diastolic pressure to vary between 84 and 120, and systolic pressure between 116 and 150, under conditions which were apparently similar. The general rise in blood-pressure, morning to evening, as above, is apparently the rule.

TABLE II.—Readings taken to show the effect of exercise upon arterial blood-pressure. The figures represent the mean values of a number of records in millimetres of mercury.

	Morning on waking.	After exercise, Time, 8 a.m.	Mid-day	After exercise.	Evening.
1.					
Diastolic ...	90	100	100	100	110
Systolic ...	120	150	130	150	130
Max. Systolic	—	—	—	160 ($\frac{1}{10}$)*	—
2.					
Diastolic ...	90	—	104	110†	108
Systolic ...	122	—	130	140	130
Max. Systolic	—	—	—	—	—
3.					
Diastolic ...	85	90	96	—	96
Systolic ...	110	130	120	—	120
Max. Systolic	—	—	—	—	—
4.					
Diastolic ...	94	—	96	94	100
Systolic ...	120	—	126	144	132
Max. Systolic	—	—	—	170 ($\frac{1}{20}$)‡	—
5.					
Diastolic ...	92	—	—	120	110
Systolic ...	126	—	—	160	140
Max. Systolic	—	—	—	—	—
6.					
Diastolic ...	88	88	100	—	106
Systolic ...	120	136	128	—	130
Max. Systolic	—	—	—	—	—

* Violent exercise taken about half an hour after a meal. Heart somewhat excitable in action; one beat in ten.
† Time—4 p.m. exercise.
‡ Exercise shortly after a meal.

TABLE III.—Readings taken to show the variation in blood-pressure observed, as a result of exercise, in the case of individuals in "training" or in want of "training."

	Usual daily variation.	After exercise "untrained."		After exercise "in training"
1.				
Diastolic	96 to 110	100	—	130
Systolic	124 to 130	170	-	160
Max. Systolic	—	180 ($\frac{1}{15}$)†	—	—
2.				
Diastolic	92 to 114	118 to 120	134*	132
Systolic	126 to 138	158	160	160
Max. Systolic	—	170 ($\frac{1}{10}$)	—	—
3.				
Diastolic	88 to 94	110	124*	120
Systolic	114 to 122	146	150	144
Max. Systolic	—	158 ($\frac{1}{8}$)	—	—
4.				
Diastolic	100 to 108	114	130*	128
Systolic	124 to 134	152	160	158
Max. Systolic	—	162	—	—
5.				
Diastolic	94 to 98	102	—	116
Systolic	120 to 124	150	—	146
Max. Systolic	—	—	—	—

* These readings taken after "second-wind."
† One beat in fifteen.

The above figures were taken from five different individuals, and represent the mean value of a large number of observations.

(*To be continued.*)

Injuries to the Eye.

CLINICAL LECTURE BY MR. ORMOND.

GENTLEMEN,—We have had a very interesting series of cases in the Eye Wards recently illustrating some of the results of injury to the eye, and although it is impossible in the space of one hour to discuss all these cases, I should like to bring some of them to your notice.

Injuries to the eye may be divided roughly into three classes:—

1. Those due to foreign bodies.
2. Those due to penetrating wounds caused by sharp instruments.
3. Those caused by blows or contusions.

The first class includes those slighter injuries in which a foreign particle lodges within the conjunctival sac, and as this is such a common occurrence a few words as to how best to deal with such cases may be useful. The foreign bodies most frequently met with are minute particles of coal dust, emery powder, or pieces of metal. Any one of these lodging within the lid is apt to produce the symptoms of pain, watering and redness of the eye, though occasionally foreign bodies may be found within the conjunctival sac which have remained unnoticed by the patient. It is noteworthy that the amount of pain and inflammation produced by a foreign body within the lids depends upon its position in relation to the cornea.

When examining the eye with a view to finding a foreign body, place the patient in front of a good light and thoroughly inspect the surface of the cornea, direct the patient to move his eye about in every direction, and if it is not then visible evert the upper lid.

If the foreign body be found embedded in the conjunctiva it may be possible to remove it with a small pledget of wool or lint, but if it has adhered to the cornea it will be necessary to use a local anæsthetic such as cocaine grs. v. ad ʒi. before it can be successfully removed by a foreign body needle or spud; a drop of this solution instilled into the eye and allowed to remain for five minutes is usually sufficient. The patient should be seated in front of, and with his back to, the operator, and a good light directed on the cornea; the lids should be kept apart by the thumb and index finger of the surgeon's left hand; the point of a sharp foreign body needle should then be inserted under the foreign body and an attempt made to lift it out of its bed.

Sometimes the offending grit is raised above the surface of the cornea, and a blunt-ended spud will be found sufficient for the removal, but all scraping and scratching of the cornea should be avoided in order to limit as far as possible the damage done to the corneal tissue. If the foreign body is very deeply embedded in the cornea it may be necessary to scrape the superficial tissue away, as the point of the needle may not do more than push it between the layers of the corneal tissue; in such cases it is necessary to enlarge the hole in order to lift the particle out.

The urgency of removing a foreign particle is due to the pain it causes, and also to the possibility of septic infection of the cornea. It must be acknowledged, however, that a septic foreign body is not likely to remain embedded for long, since by its very nature the ulceration around will tend to loosen its hold on the corneal tissue, and it will fall out or be thrown off in the discharge. The practical point to be remembered is that it is never worth while inflicting extensive damage on the cornea in order to remove a foreign body, because it will probably detach itself in the course of a day or two, though it is essential to control any septic process which might lead to a spreading ulcer.

After having removed the foreign body, the treatment of the eye is that appropriate to a traumatic ulcer. The conjunctival sac should be thoroughly washed out with some warm boric lotion; should there be much inflammation, atropine may be instilled, and if there is pain cocaine should also be used and a bandage applied.

A foreign body with sharp edges often pierces the cornea or sclerotic, and may be found lodged within the eye; if it can be seen in the anterior chamber an incision should be made in its immediate neighbourhood and an attempt made to remove it with a pair of iris forceps. After incision of the cornea the foreign body is sometimes carried outside the eye by the rush of aqueous as the knife is withdrawn, but if it is entangled in the iris it may be necessary to perform an iridectomy. If, however, the metal has entered the eye with force sufficient to carry it to the posterior part, it may be embedded in the retina or choroid, and is hidden from sight; consequently, any attempt to use an instrument in order to withdraw it would cause more damage than would be caused by the presence of the offending substance itself, and this is also true in cases where the foreign

body can be actually seen. Under these circumstances, if the foreign body is metallic and can be magnetised, the best method of extraction is by Haab's electro-magnet. One of these instruments has recently been placed in the eye wards. It is a very powerful electro-magnet, and consists of a nucleus of soft iron surrounded by a massive covering of copper wire through which a constant current of electricity is passed.

A skiagram should be taken before using the magnet in order to aid the operator in directing the position in which the patient's head should be held. The magnet, however, will often withdraw minute fragments of steel from the deep parts of the globe which have escaped detection by a skiagram. We have had two cases lately in which metallic particles have penetrated the tunics of the eye-ball. The first case is that of a man who was last September chipping stone with a steel hammer and chisel. "Something" struck his left eye, and almost at once he noticed that his sight had become dim in that eye. Now it is obvious that what struck the eye might have been a portion of one of three things—the hammer, the chisel or the stone; as a rule we find that it is a piece of the hammer or the chisel, and less frequently the stone or material on which the man is working. This case was no exception, as the foreign body proved to be metallic.

The man was admitted into the hospital, and after some delay a foreign body was accurately located by means of a skiagram. Its position was found to be 3 mm. outside and 6 mm. below the centre of the cornea and at a depth of 6 mm.

On examining the fundus with the ophthalmoscope, there could be seen in this position a white filmy mass in the vitreous, which did not in the least suggest a piece of metal. It was seen to have a movement of its own independent of the movement of the eye, which showed that it was lying free, or only loosely attached to the vitreous. This white mass was no doubt the result of some inflammatory exudation, and it entirely obscured the foreign body itself. It was, however, in the position indicated by the skiagram, and showed the exact position of the metal. The pupil was dilated with atropine, the conjunctival sac thoroughly washed out and cocaine instilled. The patient was then seated in front of the Haab magnet in such a position that his eye was immediately opposite the point of the magnet, and at about an inch from its apex. After the electric current had been started the patient complained of severe pain in the eye; this was good evidence that a metallic particle was in the eye. On increasing the current it was further noticed that the cornea was being drawn forward, and on making the patient look down, and applying the point of the magnet to the upper part of the eyeball, the foreign body was quickly brought into the anterior chamber. The patient was then put on the operating table and an incision made on

CASE I.

the lower and outer part of the cornea, and the piece of metal was removed with a pair of iridectomy forceps. After the metal had been removed it was found impossible to replace the iris, which had prolapsed. This necessitated an iridectomy. The vitreous, although presenting in the wound, did not escape; its presence was caused by the laceration of the hyaloid membrane and suspensory ligament, due to the force with which the magnet had attracted the metal. The eye was then tied up and the patient put back to bed.

The other case in which I used the magnet was that of a boy æt. 15, who was working with some metal when a piece flew up and struck his left eye. He was sent up to the hospital almost immediately, and as the history suggested the presence of a piece of steel within the eye the magnet was used at once for purposes of diagnosis. In this instance the piece of metal was so minute that when it had been drawn into the anterior chamber by the magnet, it was seen distinctly sticking to the deep surface of the cornea, and was held there by the force of the magnet, but it entirely disappeared from view when the electric current was stopped, since it fell down to the bottom of the anterior chamber and was lost behind the scleral rim. However, having noticed the position where it fell I made an incision over the place, but I was not fortunate enough to be able to withdraw it with a pair of finely-toothed forceps. The patient was therefore for a second time placed in front of the magnet, the sharp point of which having been carefully sterilised, was gently inserted between the lips of the wound. The electric current was then started, and after a short period the boy's head was drawn away, and the piece of metal was found attached to the apex of the magnet. The iris, which had prolapsed, was then replaced and the eye dressed. Two months after the accident his vision was $\frac{6}{9}$, and the eye, except for a slight irregularity of the pupil, looked perfectly normal.

Another case we have had in the ward recently is that of a man who in May last was working on a piece of wrought iron with a hammer when a portion of the metal, half an inch long and a quarter of an inch thick, flew up and hit him on the right eye. When first seen there was a scar on the inner and lower part of the eyeball, in the ciliary region, and the conjunctiva was very much inflamed. On examining the fundus, the pupil was found to be dilated and fixed, but no red reflex could be obtained, and the patient's vision was reduced to perception of light. A skiagram was taken and no metallic foreign body could be discovered. We had, then, a case in which, owing to a contused blow, the eyeball had become filled with blood, and for some time it was impossible to diagnose the extent of the damage. A few days after the accident the blood had become absorbed from the anterior chamber, and it was noticeable that the peripheral angle of the anterior chamber was deeper than usual and the pupillary margin pushed forward. The eye was kept tied up, and gradually the inflammatory symptoms subsided, but the vitreous haze had not sufficiently cleared for two months to admit of the fundus being seen. On August 12th, that is to say, three months after the accident, I made the following note: "The scar at the lower and inner part of the sclerotic has healed, there is evidence of old traumatic iritis and some large floating opacities exist in the vitreous. On the inner side of the optic disc is a linear crescent-shaped scar, due to a rupture of the choroid. The patient was able to count fingers at two yards." The main point to be noticed about this type of injury is its liability to produce damage by "contre-coup."

Blows upon the anterior portion of the eye not infrequently cause a tear in the choroid. The rent is usually in the neighbourhood of the optic disc, its concave margin being concentric with the margin of the disc. At first, as in our case, it is often impossible to diagnose this condition owing to the vitreous being rendered opaque by the extravasation of blood into it, but when this has cleared the rent can be seen with the ophthalmoscope. Such injuries are easily recognisable because of their uniformly crescentic appearance. Owing to the tear the sclerotic is exposed, the retinal vessels are seen to pass over the white area, and frequently pigment is formed at the edge of the rent. Pictures representing the condition may be seen in Frost's Atlas, Plate xxx., and also in Haab's Atlas, Fig. 74. These scars usually remain unchanged, but some cases have been recorded in which further changes have taken place, these being in the nature of patches of pigment and patches of choroidal atrophy. As the site of the rupture is usually near the macula, vision is seriously interfered with.

The fourth and last case in which I wish to interest you to-day is that of a man æt. 23, who in August last was riding on the tail-board of a van, which in turning the corner at Dockhead swung him off; he fell, striking the right side of his head and right shoulder. When picked up he was a little dazed, but not unconscious. He came to the hospital and was admitted into a surgical ward. When I first saw him, which

was some days later, there was paralysis of the left 6th nerve, and the patient stated that he was quite unable to see anything with his right eye; he could not even perceive light. The eye appeared to me to be perfectly healthy. There was no bruising of the lids; the conjunctiva was unaffected; the cornea and lens quite clear, and the fundus oculi showed nothing abnormal. The only unusual symptom was the dilatation of the pupil. On inquiry I found that atropine had been used in order to examine the eye. Here, then, was a case in which a patient stated that he was totally blind in one eye and yet that eye was perfectly healthy in appearance. It was very important to verify this man's statement, because in this, as in similar cases, the question of compensation might arise. I suggested that no more atropine should be used, and an examination of the eye a fortnight later revealed the fact that the pupil had contracted and that it did react to light; when, however, all light was excluded from his seeing eye, *i.e.*, the left eye, the right pupil dilated and remained unaffected by the strongest light. That is to say, the patient retained the consensual light reflex, but had lost the direct light reflex; this was the only evidence which we had to prove the patient's statement, which was, of course, true. I have seen this patient many times since, and the pupillary condition remains the same; he has, however, regained the use of the external rectus of his left eye.

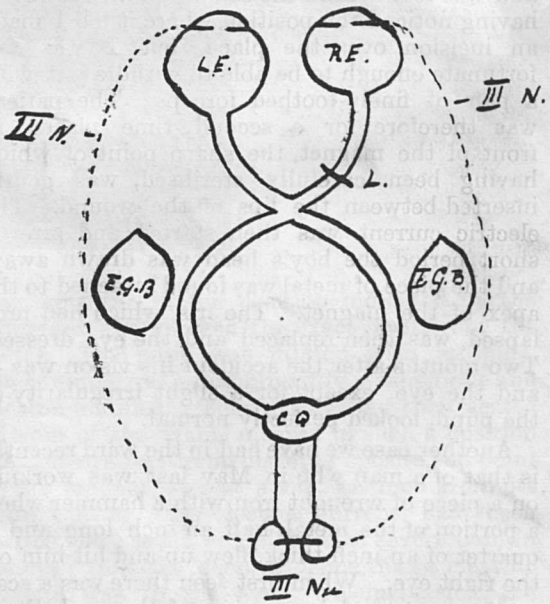
Let us now consider what could be the position of the injury which caused these symptoms of blindness and immobility of the pupil to direct light, whilst the consensual reaction remained as usual. The entire absence of vision suggests the optic nerve as the seat of injury. If the damage had involved the brain or optic tracts, both eyes would have been affected. The loss of an entire sense of light also negatives any suggestion of the lesion being in the eye itself. We must, then, locate the injury somewhere between the optic chiasma and the globe, that is to say, in the nerve itself. But the optic nerve does not only consist of fibres which are concerned with vision; the optic nerve contains fibres of varying sizes, and it is possible that these fibres vary in function. It is quite certain that the afferent pupillo-constrictor path passes through the optic nerve, undergoes partial decussation in the chiasma, as is proved by the hemiopic pupillary reaction, and continues into the optic tracts, from whence they travel as far as, but not into, the external geniculate body; thence by a purely conjectural path they reach the nucleus of the third nerve, and fibres pass to the nucleus of the same and also of the opposite side. The centre for the reflex arc is about the middle of the nucleus of the third nerve.

The efferent path is through the third nerve itself. If, then, light is thrown upon the pupil of the right eye, the left pupil contracts as well as the right, because the stimulus is conveyed to both third nerve nuclei, and from them through the third nerves to the two eyes, although only one afferent path has been used.

In our patient this contraction occurred when light was thrown upon the left or seeing eye, but not when it was thrown upon the pupil of the right. Therefore we know that the damage to the reflex arc must be in such a position as to involve the optic nerve of one eye.

The patient's loss of vision is, of course, entirely subjective, but the loss of direct pupillary reaction to light is objective, and the only position for any injury to exist which will explain all his symptoms, both objective and subjective, is in the optic nerve of the right side far back in the orbit.

The accompanying diagram may make some of the preceding statements clearer:—



E.G.B.—External Geniculate Body.
C.Q.—Corpora Quadragemina.
L.—Site of Injury.
III. N.—Third Nerve.
III. Nu.—Third Nerve Nucleus.

We may then conclude that probably this patient sustained a fracture of the base of his skull, and the fracture passed through the apex of the right orbit severing the optic nerve at the optic foramen. This suggestion would also explain the damage done to the sixth nerve of the opposite side, but in that case the subsequent recovery of the external rectus muscle suggests that there was no severance of the nerve fibres, but possibly only hæmorrhage into the nerve sheath.

Guy's Hospital.

TABLES showing total number of Patients sent during the past year to various Convalescent Homes connected with the Hospital, and the amounts found in the Collecting Boxes, together with special donations.

WARDS.	NUMBER OF PATIENTS. 1907.	1906.
Astley Cooper	17	35
Cornelius	14	24
Lazarus	22	33
Job	34	30
Naaman	32	46
Luke	21	25
Patience and Samaritan	18	32
Charity	61	31
Dorcas	18	29
Lydia	46	46
Martha	33	33
Eye Wards	11	9
Addison	111	75
Mary	74	56
Stephen	65	53
Esther	78	71
Queen Victoria	59	50
Clinical	78	80
Isolation	1	1
Surgery	1	11
Out-Patients	38	49
Total	832	819

The subjoined list gives the distribution of the patients amongst the various Convalescent Homes:—

Ascot Priory	145
Barnet (Children's Hospital)	6
Bexhill (M.C.I.)	14
Bognor (Merchant Taylors')	24
Brighton (Barclay Home)	1
" (St. Oswald's Home)	1
Broadstairs (M.C.I.)	139
Chirk (Lady Trevor's Home)	4
Gringley (Col. Laycock's Home)	12
Hampstead (Friedenheim)	1
Hassocks ("Sunshine" Home)	1
Littlehampton (Rustington Home)	15
Margate (R.S.B. Hospital)	1
Swanley	254
Walton-on-Thames (M.C.I.)	61
Windsor (Murray Home)	1
Worthing (Miss Henry)	147
" (St. Mary's)	4
" (Y.W.C.A.)	1
Total	832

List of Amounts received from Patients in the various Wards, and sums found in Ward Collecting Boxes, etc., for the year ending December 31st, 1907. The amounts received in the previous year are inserted for the purpose of comparison.

	Box Collections. 1907. £ s. d.	Special Donations. 1907. £ s. d.	Totals for 1906. £ s. d.
Counting House	12 10 10	—	11 8 10
Office of Secretary to Treasurer	1 14 6	—	2 10 0
Front Gate Box	9 0 11	—	11 16 3
Porter's Lodge	27 19 1	—	28 18 3
Surgery	6 7 2	1 3 0	8 17 0
Out-Patient Dept.	112 15 0	—	117 14 1
Conservation Room	—	—	4 11 4
Actinotherapeutic Department	1 16 8	29 14 0	39 8 9
Massage Department	0 8 2	—	2 16 2
WARDS—			
Addison	2 19 9	3 3 0	13 1 8
Astley Cooper	4 1 5	—	0 16 4
Bright	2 14 7	3 1 0	11 17 5
Charity	2 7 4	5 0 0	8 13 5
Clinical	5 17 11	14 10 0	0 17 2
Cornelius	0 8 9	—	5 5 10
Dorcas	5 15 6	40 5 0	55 10 6
Esther	3 0 9	—	1 16 9
Eye	2 15 10	10 10 0	11 2 3
Job	4 2 1	7 2 0	12 19 1
Lazarus	6 2 9	24 12 0	14 16 7
(Legacy)	—	50 0 0	—
Luke	3 11 3	32 11 0	25 14 11
Lydia	4 9 5	2 2 0	15 14 11
Martha	3 8 9	13 3 0	1 9 9
Mary	2 13 3	—	7 2 6
Naaman	7 5 8	29 19 6	24 8 6
Patience	0 7 7	—	1 0 10
Queen and Victoria	11 6 2	64 10 0	45 15 5
	1 4 6	15 0 0	0 13 9
Stephen	0 15 7	3 1 0	3 19 8
	£248 1 2	£349 6 6	£490 17 11
Total	£597 7s. 8d.		

Rome as a Winter Health Resort.

BY FREDERIC VICARS, M.D.

SOME remarks on the above may be useful to readers of the GAZETTE, if only to correct a very general idea that Rome is not healthy, and consequently not a suitable place of residence for invalids. My personal knowledge of Rome is too limited at present for me to express my own views, however favourable my impressions are. I prefer rather to gather information from competent authorities who have studied and written about this subject. Among these authorities stand first the Italians Mendini and Santoliquido; while amongst English doctors in earlier times, Sir James Clarke and H. Weber may be quoted. The most up-to-date authorities, however, are Doctors Welsford, Brock, and Eyre.

To speak of Rome as a health resort one has first to endeavour to dispel the firmly fixed idea that it is a malarious and fever-haunted city. This classic idea is wholly incorrect. During the last twenty years sanitation has progressed by leaps and bounds, so that, to quote one authority, "Rome of to-day is as healthy as any city in Europe." As for malaria, or the so-called "Roman Fever," it does not exist now. The cases of malaria in Rome are those imported from outside, either from the peasants living in the Campagna—the country around the city—or among those whose duties take them into that unhealthy and malarious district. The severe cases from the Campagna are brought into the Roman hospitals, thus swelling the list of malarial cases. From July to the end of September is the unhealthy period in the Campagna. From October to June malaria does not exist there, the mosquitos remaining dormant throughout this period, and thus Rome itself is free from any contagion.

With regard to enterica, formerly so prevalent, sanitary measures have again triumphed, and the following quotation from Welsford's tables, showing the mean annual death-rate for 1891–1900, for ten large cities, form a satisfactory comparison.

Dublin	·533	Portsmouth ...	·242
Liverpool ...	·342	Glasgow	·241
Rome	·294	Norwich	·229
Sheffield	·294	Manchester ...	·225
Nottingham ...	·284	London	·135

During period 1901–1905 the mortality has been ·38 per thousand, which is higher than formerly. At first sight this increased mortality does not give a favourable impression, but it is correctly accounted for by the overcrowding in certain poor districts, due to the displacement of the population to make room for improved and better class buildings elsewhere. The visitor dwelling in hotels and the better class pensions run practically no risk, and in consequence among the Anglo-American community the death-rate may be said to be nil.

The zymotic death-rate compares favourably with London. Compulsory vaccination and re-vaccination have banished small-pox here. Measles death-rate in 1905 was only ·3 per thousand, and that of scarlatina ·007. The diphtheria death-rate for 1896–1905 was only ·11 per thousand, which is lower than that of England.

The splendid water supply and the frequent flushing of the sewers which carry the sewage to a distance below the city have remedied the old state of affairs. During the past ten years the death-rate of Rome has been 19·6 per thousand. The Roman climate resembles that of the French Riviera, and the mean temperatures of the winter and spring are practically the same, but Rome is certainly less windy and dusty. From October to June there are on an average one hundred clear sunny days. The prevailing winds are the south, known as the "Sirocco," and the north, the "Tramontana." The Sirocca is the warm wind and brings with it rain. The Tramontana is considered bracing and stimulating. Educated opinions differ as to the influence of the Sirocco and Tramontana. Some find the warm wind soothing and restful; others think it depressing. The north wind to some is stimulating and healthful, while others regard it as treacherous and unpleasantly cold. The water supply is of excellent quality and abundant in quantity—a daily supply of 112 gallons per head. It is bacteriologically pure. In regard to what cases of illness the Roman climate in winter and spring is considered suitable, I should say nearly all chronic cases would derive benefit here. The absence of strong winds, the small amount of dust, the soft air, the calm life which can be lived here by invalids, all make for health. The great amount of sunshine enables patients to spend a good deal of time in the open air. Bronchial catarrh becomes quiescent in this soothing atmosphere, and gouty and rheumatic cases generally derive much benefit from the dry soil, low relative humidity, and general climate. Nasal and throat troubles improve here, and cases of insomnia derive great benefit. The chief danger to health is to be found in the unreasoning habits of certain visitors who insist on ignoring the fact that it is not wise to go out of the hot sun into a cold building. To the sightseer this is an ever-present danger. There is a large class of English women whose chief aim in life is "to be cool." These thoroughly enjoy draughts and the bracing effect of cold. They wear very little under-clothing, and in summer like their anatomy to be clearly defined under a gown of thin material. They seem to have a perpetual hankering for the barbaric ages, when their ancestors' sole covering consisted of a smear of Woad! Such persons are likely to suffer in Rome. But the matter is entirely in their own hands. It is merely a question of suitable clothing and an extra wrap when necessary.

A Boxing Day Reverie.

BY A PATIENT IN BRIGHT'S.

"Long stood Sir Bedivere,
Revolving many memories."

AND even as the knight, the sole survivor of the côterie of the Round Table, pondered at the brink of the Cornish mere, so does the surgical patient find himself afforded similar opportunities of self-commune as he lies recumbent in the ward of the vast hospital which buries its hugeness in a quiet street only a few hundred yards from the stir and hum of the Borough High Street.

I have been asked by a Great Personage to write my impressions of a Christmas Day spent in hospital, and although in this instance the pen is certainly not mightier than the sword —even than a sword some time since turned into a ploughshare—one must bow to the command of Him who is to be obeyed.

A Christmas in bed has not been an entirely new experience, as two years ago, a slave to the demon influenza, I spent the festive season in the dreary solitude of a bachelor's diggings; a few years previously, too, in the special case ward of a station hospital in South Africa, worried to the verge of insanity by flies and a three-figure temperature. The third and present occasion will always remain a pleasant memory when the other two have been long buried in a well-merited oblivion.

Surely in no community is the message of peace and goodwill so heartily propagated as in the precincts of Guy's; and from the evening of the 23rd, when one's last waking moments were soothed by a German band, whose trombone held a strong lead, retailing the oft-told story of King Wenceslas, till the last mince-pie was swallowed at supper on the 25th, all went as merrily as the proverbial marriage bell.

Our first treat, and one of the very highest class, was late on Xmas Eve, when the choir of Southwark Cathedral sang a succession of carols which they rendered most exquisitely, and which were most highly appreciated by their audience. As their musical strains were wafted from the regions of the operating hall, the thought flashed across one's mind as to whether any of the selections were taken from the "Appendix."

After a night of feverish anticipation (how many times did Master Jacky ring his bell to know if Father Xmas had yet arrived?), Xmas morning is ushered in by a choir of sweet contralto voices singing the glorious old-time hymn, "Hark, the Herald Angels Sing," which again gives rise to the revolving of memories, and brings out vividly the meaning of the word Empire, when one thinks by how many millions of voices, and in how many various parts of the globe where the Union Jack flies, will the same chant be sung to-day.

Breakfast having been served, and the "morning stable" hour being over, during which each patient has been groomed and tidied up for the day, the arrival of the letters forms the next excitement, and at 12.30 he must indeed be a bad case who is not permitted to attack the traditional Xmas fare of turkey, plum-pudding, and mince-pie, even though he may have to content himself with a foaming beaker of nothing more invigorating than milk and soda with which to pledge the particular toast that may take his fancy.

After dinner came the *pièce de résistance*, when, with rattle of drum and squeal of fife, the nigger troupe made their long-looked-for entrance. But here the writer is brought into hearty sympathy with the caged animals in Regent's Park; the walls of his cubicle so curtailing his powers of vision laterally, and in a manner quite sufficient to account for the surly and disappointed air habitually adopted by a denizen of the Zoo. As the gaily-dressed mummers file past in kaleidoscopic succession, it is hard to particularise, but one has time to grasp that the procession is headed by a member of the Police Force, followed by a heterogeneous crowd, out of which it is possible to detect a Red Indian, an appropriately Black Friar, an Incroyable, a dashing Lancer, and, surely, our old favourite, Harry Lauder, fresh from his triumphs across the Herring Pond. A rousing "View hallo" rings out from the patients of Bright's as they espy their ever-popular "Docthor Darlint," whose identity is unimpeachable, even though disguised in the splendour and dignity of raiment with which the brush of C. Dana Gibson has rendered us familiar.

The exertions of the modern two-house-nightly entertainment pale before the efforts of this devoted band, who carried out a seven-hour programme that never flagged from start to finish, and each inmate of Guy's owes a heavy debt of gratitude not to these public-spirited gentlemen only, but to every individual member of the Staff who has given up the pleasure of a Christmas in the home circle in order to cater for the amusement of those forced to spend it within its hospitable and gaily-decorated walls.

Ladies and Gentlemen of Guy's, the patients, one and all, although by no means admitting themselves to be "Morituri—te salutant," and, while thanking you for a very Merry Christmas, unite in wishing you a Happy New Year.

Dental News.

The advent of the New Year sees many changes in the Dental Department—not in the building itself (that is promised for a *future* date), but in the inner workings of the department.

The appointment of Student Demonstrator in the Conservation Room has been done away with, thus avoiding the unpleasantness sometimes arising when a man, perhaps only just in his second year, comes to demonstrate to an "old crock" who is many years his senior.

There are to be three Dental House Surgeons and three Assistant House Surgeons, the former duties of the Student Demonstrators falling on the House Surgeons, who will change duties each week. There will be a House Surgeon on duty in the Ordinary Extraction Room each day from 9 a.m., instead of 9.45, as heretofore, thus shortening the agony of suspense experienced by the patients waiting to go into the Extraction Room.

It will be the duty of two of the Dental House Surgeons to attend to the teeth of the Nursing Staff, the other House Surgeon being appointed Assistant Curator in the Dental part of the Gordon Museum, where he will spend two afternoons a week.

We welcome these changes as a step in the right direction, and wish the new comers every success.

Mr. Frederick N. Doubleday has now been appointed Dental correspondent to the GAZETTE, the term of office of the present correspondent having now come to a close.

Appended will be found the new Dental Appointment list.

Dental Appointment List.

Dental House Surgeons.—Messrs. R. J. Gibbings, G. Hunt, I. S. Spain.

Assistant Dental House Surgeons.—Messrs. H. V. Gibbons, C. C. Jones, E. E. Solomon.

Assistant Demonstrators of Dental Mechanics.—Messrs. E. A. Tomes, W. S. Lacey.

Assistant Demonstrators of Dental Metallurgy.—Messrs. J. Roberts, G. H. Hickman.

Assistant Curator of Museum.—Mr. G. Hunt.

Miller Fund.

	£	s.	d.
Capt. H. Watts, I.M.S., Amhala City, India	1	1	0
Dr. Arthur Pearson, Rhodesia	1	1	0

Guy's Physiological Society.

A meeting was held on Monday, December 16th, at which Mr. Thompson presided. Mr. Foster-Smith read a paper on "Vivisection aud Anti-Vivisection."

The first official vivisector was one Herophilus, who, about 300 B.C., not only practised on animals, but also on 600 criminals. We read of subjects for vivisection being obtained from the latter class as late as 1545 A.D. From the middle of the sixteenth century there has been a steady increase in the use of vivisection experiments, and of late years a corresponding growth of the anti-vivisection movement. In 1875 the Government took action by appointing a Royal Commission to inquire into the practice; the recommendations of this Commission were adopted by the Government and brought into force. However, it was considered necessary to appoint another Royal Commission in 1906, which is still sitting; the majority of vivisectors are in favour of the first Act remaining unchanged.

The objections raised against visisection are based on scientific, moral, legal and sentimental grounds. The first class of objections are brought forward on the assumption that vivisection experiments are useless. The majority of anti-vivisectors argue from the moral standpoint; they affirm that man has no right to make use of knowledge bought at the expense of animal torture. To exploit an animal for any purpose whatever—to the disadvantage of that animal—is immoral; moreover, they say the witnessing of vivisection experiments tends to brutalise students, that experiments on animals in lectures are unnecessary, and the purely academic work performed in experimental courses of physiology is of little use to the majority of students.

The Act at present in force presents many inconsistencies. It has been suggested that all vivisectors should be required to produce certificates of humanity—a suggestion which is not altogether frivolous when we regard the opinions of certain experimenters. Vivisection is to be regarded as a disagreeable necessity.

The Society owes its gratitude to Mr. Foster-Smith for stating the case with a fairness which is obscured by the rabid enthusiasm of other writers. A long discussion followed, which lasted for two hours, and was, on the whole, remarkable for the same fairness which characterised the paper.

At a meeting held on Monday, January 6th, the chair was occupied by Mr. Mollison. Mr. H. S. Hopkins read an interesting article on "Nicotine."

He began by taking a brief survey of tobacco as an article of history and commerce. The name of its principal constituent, we were told, was derived from that of an enterprising Frenchman, Jean Nicot, who sent a present of the fragrant weed to Catharine de Medici. In spite of strenuous opposition by Church and State, the consumption at the end of the 17th century was, proportionately, as great as that of to-day. After

giving the composition of tobacco in general, and certain varieties in particular, the author turned to the physiological aspect.

The effects of smoking differ greatly in different persons, as the relative tolerance of the different constituents of tobacco smoke varies, and, therefore, the final decision, whether to smoke or not, rests with the individual and the medical adviser. When taken in moderation, tobacco is beneficial to most people, but it is always injurious when taken in excess.

Juvenile smoking should be prevented by every means in our power. Nicotine might undoubtedly gain entrance to the system through the medium of tobacco smoke, but it was doubtful whether it was the principal agent in producing the sedative and other characteristic effects, which might be due largely to self-suggestion, or, perhaps, to the continuous rhythmic movement of the lips. Mr. Hopkins concluded by quoting Professor Pitman: "Allowing that incidental evils may arise, even from comparatively moderate indulgence in tobacco, they are as nothing compared with the vast aggregate of gentle exhilaration, soothing and social comfort extracted from the fragrant weed."

A Quaint Epistle.

THE following epistle—in the form of a post-card—was received recently, addressed "House Surgeon," and marked "Pressing and Important." Comment would be superfluous:—

SIR,—Seeing on page 6 of to-day's *Standard* an account of a person dying under chloroform at your hospital, I would like to call your attention to an article which appeared in *Daily Express* (a London ½d. daily) on 4th October, 1902, and in *Lloyd's*, *Budget*, and *People* same week. It is an account of a successful experiment which brought cats, dogs, bees, flies, and 1 drowned boy (given up for dead by doctors) to life after hearts ceased beating. The subjects were placed in a warm plate, or cloth, and entirely covered with the following powder, after which life appeared:—

EXTRACT FROM ARTICLE.

"The doctor makes use in his experiments of a ligh salt solution, saturated with oil of the body, which allowed to stand exposed in an atmosphere of free ammonia. From this solution a powder is derived, and it is this powder which contains the life-renewing properties."

Now, Sir, as above subjects died through chloroform and were brought to life, kindly try experiment on the man's body, and publish widely if successful. Also send this card, or a copy of it, to the House-Surgeon, Great Northern Hospital, *immediately*, as I want him to try same on body of a man who also died under chloroform, as reported in to-day's *Standard*. *Please do both at once—saving, perhaps, valuable lives.*—Yours respectfully, X.

8th January, 1908.

Some Extracts from an Address delivered by Dr. Scott Skirving to the Medical Society of the University of Sydney.

"You may, indeed, be an excellent student, a faithful digester of text-books, a medallist perhaps, and yet, in the active conflict of life, in capacity for usefulness to your fellow men, you may fall deplorably short of what the promise of your academic career foretold.

I believe such failures are not seldom due to lack of common sense, to want of tact, to absence of sympathy, to an inability to understand your fellow men, men and women, like yourselves—full of failings, weaknesses and turbulent emotions."

"A good text-book, Gentlemen, has a price, as was long ago said of something else, "far above rubies;" but even the beams of crystallized knowledge and experience which sparkle from the pages of Osler are not the last words on the Practice of Physic."

ON COMMON SENSE.

"Common sense is a form of knowledge which is partly a gift born with the individual, and partly learnt by rubbing shoulders with the world."

"A due sense of proportion, and of the fitness of things, I suppose, underlies everything which we call the exercise of common sense. Those who possess it take sane, rational, and just views of things and events, and, in its application to our art, believe me, it is the common-sense practitioner who is the man to be trusted—one whose balanced judgment, abhorring extremes, makes him a safe guide in times of trouble and doubt."

These thoughts on common sense in the conduct of affairs in general, lead me to speak of the use of our common senses in affairs Medical.

By the time you reach your fifth year of study you have, I doubt not, grasped the franker aspects of certain grave maladies.

You know the earthy cachexia and emaciation of immedicable malignant disease.

You are familiar—who is not?—with the pathetic picture of the consumptive warming his sere body in the rays of a sun which he will soon see no more—you know his narrow chest, his stoop, his transparent ears, and prominent cervical vertebræ. So also is the facies of lethal abdominal disease a common object of the wards. A picture painted for all time by the Father of Medicine, finished, complete, and without addition, in two thousand years:—

'The loss of ease, the gasp for air,
The visage drawn, and Hippocratic stare,
The darkening dream, the lost control,
The sleep, the swoon, the arousal of the Soul.'

It is not, however, so much to these clearly-drawn presentments of human decay that I draw your attention, but rather to the lesser shades of visible ill-health which do not lend themselves to word-painting.

These, then, I beg of you to study and remember. Their delineation is not found in text-books, and I do not know that a knowledge of them can be communicated by word of mouth. But this folk-lore of our profession, often possessed by sisters and experienced nurses, exists, and only grows slowly by experience—stored up in the brains of shrewed old practitioners and wise nurses—whose sight, touch, and smell, corrected by years of observation, make them often able to predict the outcome of a case when sometimes even the diagnostic methods of modern medicine are silent in their power of prophecy."

ON NOT TAKING YOURSELVES TOO SERIOUSLY.

Gentlemen, there are many persons who take themselves too seriously. Do not fall into this error. It would ill become me to glorify the cult of frivolity and hedonism; but there exists the other extreme of thinking all you think, say, or do, must needs be right and wise because you say or do it. This was the attitude of mind of Gladstone—and the mischief of it was that he pursuaded others by his strong personality and the magic of his golden speech, to believe also in everything he said or did. Hence the disgrace of Majuba and the martyrdom of Khartoum.

Believe me, Gentlemen, we all say and do daily things which are neither weighty nor wise—happy are we if those who might be unwisely swayed by our speech and act have the wit to see that we are anything but safe pilots, and still happier are we ourselves if in our own inner consciousness we are also able to separate frothiness of talk and lack of true judgment from our real bed-rock of opinion and conduct.

SOME HUMILITY IS AN EXCELLENT POSSESSION, AND SWELLED HEAD IS A BAD DISORDER.

The very finite range of our knowledge of the infinite of Medical Science should make us modest and humble-minded—and cause us to remain students all our lives. Let not even a too precipitate matrimony, with its added responsibilities, unduly divert your minds from the steady serious study of your art. Lastly, Gentlemen, I think that we should all take a course of that best of all medicines for such parochial narrowness—the seeing of other countries, other men, other methods, and other modes of study.

OF STANDING UP FOR PRINCIPLES.

In the struggle for existence, in the scramble of life, where the air is acrid with the dust of opinions and the chaff of words, it is an easy way of getting comfortably along by giving way in all things. But this amoeba-like behaviour, carried to its ultimate conclusion, would fill the land with invertebrates whose motto would be "Peace at any price." Truly an ignoble calm. Most surely, then, we must, on occasions, without heat and without venom, stand up and fight for what we believe to be just and true. If the matter about which we are prepared to do battle is really important, we can afford to make a few enemies by standing "four-square to all the winds that blow."

In lesser matters, a kindly spirit of compromise and reasonableness is most likely to help the points at issue to a satisfactory settlement. In most matters, surely, compromise of some kind is allowable, and the line best to pursue. You will find later, when you are face to face with the small jealousies and heart-burning of professional life, how necessary compromise and "sweet reasonableness" are in keeping clear of unpleasantness, and in settling them when they arise, as they surely will, for we are all a good deal lower than the angels.

OF THE STUDY OF MEN.

But it is not a company of angels with whom we live, but men—and it is well to make them a close study. When I use the term "man of the world," I mean one who knows men, and the world in which we live. To be a successful doctor, one must know one's fellow man—his weaknesses and foibles and, let me add, his occasional nobility. The minds of your patients, with all their complex emotions—ambition, hope, fear, affection, which sway their actions—play no small part in the shaping of disease and the chance of helpful treatment.

It is useless to physic the body when the mind is sick with disappointment and anxiety. Therefore, Gentlemen, we must try to attain, without idle curiosity, an insight into men, in their inner life, and to remember that the whole gamut of human passion may be at times against our endeavours to cure; or, if properly handled, may be enlisted in the service of therapy. A little pinch of happiness may help a wound to heal and bring colour to some sallow face, if we only knew where to find that pinch of mental sunshine.

(To be continued.)

Appointments.

Civil.

SPRIGGS, N. I., M.D. Lond., F.R.C.S. Eng., has been appointed Certifying Factory Surgeon for the Shrewsbury District, Co. Salop.

Papers by Guy's Men.

Malignant Endocarditis, lasting over six months without Bruit. By Robert Capes, M.R.C.S., L.R.C.P., (with Chart).—*British Medical Journal*, 28th December, 1907.

The Modern Treatment of Cleft Palate. By W. Arbuthnot Lane, M.S. Lond., F.R.C.S. Eng.—*The Lancet*, 1st January, 1908.

A Case of "Mirror-writing." By Vaughan Pendred, M.D. Durham, F.R.C.S. Eng.—*Ibid.*

Orthopædic Surgery. By A. H. Tubby, M.S. Lond., F.R.C.S. Eng.—*Practitioner* for January, 1908.

Three Lectures on Surgical Diseases of Children. By A. H. Tubby, M.S. Lond,, F.R.C.S. Eng., Lecture I.—*The Clinical Journal*, 1st January. 1908.

Reviews, etc.

The price of books submitted for review should in every case be stated.

Medical Laboratory Methods. By H. French, M.A M.D., F.R.C.P. Second edition. (Balliére, Tindall and Cox.) 5s. net.

A second edition of the above excellent little book has been published. Not only has the letterpress been altered, but also a heavier paper substituted, and many new diagrams included, yet this useful manual is still in the compass best adapted for laboratory reference. Amongst the new features, predominant are the excellent re-drawn diagrams, and especially the two-coloured full page plates, one on the blood and the other depicting the common bacteria. Many new tests have been added, and the new chapter on the Preservation and Staining of Morbid Anatomy Specimens will be found to be most useful. A new paragraph on obtaining the Opsonic Index and the tables of various differential blood-counts are two additional factors which, of late, many have felt the need of. Indeed, this splendid little manual is one which we heartily recommend; in fact, one which is essential for every medical laboratory worker to possess.

Some of the Clinical Aspects of Pneumonia. By Donald W. C. Hood, C.V.O., M.D., F.R.C.P. (John Bale, Sons & Danielsson, Limited, London.)

This book is a collection of the clinical lectures and demonstrations on this subject delivered by the author at the West London Hospital. Pneumonia is discussed in all its various garbs, the first chapter dealing with those cases of pneumonia in which the symptoms simulate abdominal conditions. The chapter on influenzal pneumonia, with the accompanying temperature charts, and also the cases descriptive of the vagaries of apical pneumonic infection, give one much food for reflection. Treatment is discussed at length, and the author is emphatic in his indictment of powerful antipyretics and lack of fresh air. Altogether this little volume makes most interesting reading, and is one which we strongly advise not only practitioners to read but also students, it making an essential addendum to the ordinary text-book description.

The Reduction of Cancer. By Rollo Russell. (Longmans, Green & Co.) 1s. 6d. net.

This is a paper published in book-form pleading for a reorganisation of our dietary system. Much stress is laid on the ill-effects of using tea and coffee in excess, and tables are published bearing out the author's statement that cancer is common in countries addicted to these beverages, as well as in those where a meat diet preponderates. As an example of the adaptability of statistics we know no parallel.

This volume, written more or less from the point of view of the practitioner, deals with the art of prescribing rather than the art of dispensing; nevertheless an excellent chapter on dispensing is included. The chapter on Incompatibility will be found useful.

A Pharmacopœia for Diseases of the Skin. Edited by James Startin. (John Wright & Co.) 2s. 6d.

An excellent little manual, consisting of the prescriptions in general use at the London Skin Hospital, some notes on diet, and a concise classification of skin diseases. It should be useful to one engaged in practise who is desirous of brushing up his dermatological treatment.

On Stammering, Cleft-palate Speech and Lisping. By Mrs. Emil Behnke. (Sampson, Low, Marston & Co., Ltd.) 1s. net.

This little book contains all the essentials of the late Emil Behnke's manual, and lucidly outlines the scientific method of improving enunciation in the case of stammering, cleft-palate speech and lisping which Mrs. Emil Behnke and her late husband have made so well known.

Publications received. — Union Magazine; Medic. Tenp. Review, Jan.; The Hospital; The Clinical Journal; S. A. Medical Record; Middlesex Hospital Journal; Polyclinic; St. Bartholomew's Journal Durham College of Medicine Gazette; London Hospital Gazette; St. George's Hospital Gazette; New York State Journal of Medicine; Calcutta Medical Journal; St. Thomas's Hospital Gazette; Manchester Medical Students' Gazette; The Prescriber; St. Mary's Hospital Gazette; The Practitioner.

Change of Address.

Dr. Richard J. Bentley, from the General Hospital, Cheltenham, to the Jessop Hospital for Women, Sheffield.

Dr. Robert Harris, from 18, Duke Street, Southport, to 7, Queen's Road, Southport.

Dr. Edmund Lloyd, from Areley Hall, Stourport, to By Bor, Soudan, via Khartoum.

Dr. Frederic Vicars, from London to 41, Via Babuino, Rome.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Appointments.

Naval.

The following appointments have been notified at the Admiralty:—

Fleet-Surgeon ROBLEY H. J. BROWNE to the *Venerable*.

Fleet-Surgeon C. M. BEADNELL to the *Donegal*; and Surgeon RICHARD WILLAN to the *Amphitrite*.

Some Cases from Medical Wards.

UNDER DR. FRENCH.

STEPHEN 19.—Æt. 33. Aneurism of descending aorta. Pulmonary signs from pressure on left bronchus. Shadow shown by X-rays. Pulsation visible on back near angle of left scapula.

18.—Æt. 5. Mitral regurgitation. Pericarditis; adherent pericardium. Varicella. Heart dilated five inches outside mid line. Retraction of ribs over cardiac apex. Large liver and spleen.

24.—Æt. 48. Bright's disease ten years ago. Headache, cough, hoarseness, œdema. Urine, acid; contains albumin and blood. Microscopically examined, blood cells, pus, no casts.

15.—Æt. 57. Two years' history of dyspepsia. Carcinoma of stomach with secondary deposits in omentum simulating growth of ascending colon. Nodules in abdominal wall. Skiagram shows stomach to be contracted.

14.—Æt. 23.—Lead neuritis, wrist drop and foot drop.

12.—Æt. 56. Locomotor ataxia; perforating ulcer; lightning pains. Argyll Robertson pupils.

ESTHER 6.—Married, æt. 47. Mitral stenosis and regurgitation. Right-sided dilatation, thrill. Systolic and mid-diastolic bruits at apex.

10.—Æt. 30. Cavernous angioma. Veins of left arm dilated from tips of fingers to shoulder, and extending up and over back and side.

UNDER DR. FAWCETT.

MARY 20.—Spleno-medullary leukæmia following malaria. Leucocytosis 560,000, decreasing in five weeks to 260,000.

48.—Mitral stenosis, acute dilatation, and tricuspid regurgitation.

ADDISON 41.—A case of primary spastic paraplegia.

34.—Cretinism.

44.—A case of glycosuria with retinal and blood changes of lipæmia.

8.—Transverse myelitis, syphilitic in origin; spastic paraplegia.

47.—Mitral incompetence.

UNDER DR. SHAW.

ADDISON 24.—Pernicious anæmia. Æt. 34. A year's history of abdominal pain and change in colour of skin. Physical signs, apical, systolic, large spleen, and yellowish skin. Colour index has fallen from 1·1 to ·89. Diarrhœa has set in lately, and slight epistaxis is the only sign of hæmorrhage he has had.

16.—Aneurysm of ascending arch of the aorta. Æt. 43. Stoker in the Navy. Five months' history of pain in chest. Pulsating tumour in third right space, two inches in diameter. No aortic bruit. No signs in lungs.

13.—Aortic stenosis and regurgitation — pyrexia. Admitted into Naaman for operation on hernia. Blood and pus found in acid urine. Transferred. Some shooting pain in right iliac fossa. To and fro aortic bruit. Liver enlarged. Skiagram—right kidney considerably, left kidney slightly enlarged. No sign of stone. Tuberculo-opsonic index = 1·2. Calamette's Tuberculo-Ophthalmic reaction negative. No T.B. found in centrifugalized urine. Patient has developed dyspnœa and a rapid pulse whilst in bed in the ward.

MARY 32.—Osteo-arthritis. Æt. 59. Three years ago finger-joints acutely attacked leaving typical ulnar deviation. One year ago knees rapidly affected after an injury; they are flexed and fixed, and osteophytes can be felt.

34.—Primary Mammary Scirrhus. Operation (one year ago). General carcinomatosis. Æt. 39. Paralysis or paresis of each cranial nerve from the first to the eleventh can definitely be made out on the left side. A study of her sharply defined anæsthetic areas is instructive. She is deeply jaundiced.

38.—Abdominal tumour. Æt. 26. Seven months' history of gradual abdominal distension. Admitted into and discharged from Victoria as not a gynæcological nor an obstetric case. Dull on percussion. On palpation thick in all directions, and three distinct lumps felt in the right lumbar region. Apex beat in second and third left costal spaces. Seventeen pints of greyish-brown viscid fluid drawn off on tapping, quickly re-collecting. Occasional right ureteric colic, thought to be due to pressure on ureter by neoplasm. Urine only between twelve and twenty ounces daily.

BOOKS, &c., RECEIVED. — French's Laboratory Methods, new edition; Mark's Maternity Nurses' Guide; Marshall's Prescribing; Ham's Report of Plague in Queensland; Gaceta Medica de Costa Rica; Practitioner for January, 1908; Journal of the Royal Army Medical Corps for January, 1908; Glasgow Medical Journal.

Births.

THOMPSON.—At 4. St, Thomas' Street, London Bridge, S.E., the wife of Ralph Thompson, Ch.M., F.R.C.S., of a son.

WORTHINGTON. — On December 29th, at The Sycamores, Birchington, Thanet, the wife of H. E. Worthington, M.R.C.S., L.R.C.P., of a daughter.

EDS.—M. E. B. & L. M.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

January.

Sat. 25. 1st XV. v. Old Merchant Taylors (Away).
2nd XV. v. Rosslyn Park A (Away).
1st XI. v. Old Tollingtonians (Home).
2nd XI. v. Old Tollingtonians A (Away).

Mon. 27. Special Clinical Lecture by Mr. Targett.

Wed. 29. 1st XV. v. Oxford University (Away).

Thur. 30. Mr. Golding-Bird's and Dr. Hale White's Take-in commences. (Messrs. J. S. Cooper and Nutman.)

February.

Sat. 1. 1st XV. v. Old Alleynians (Home).
2nd XV. v. H. R. & S. Banks (Away).
1st XI. v. Weybridge (Away).
2nd XI. v. City of London School (Home).
Physical Society's Meeting, at 8 p.m.

Mon. 3. Special Clinical Lecture by Mr. Eason.

Tues. 4. Dental Clinical by Mr. Parfitt.

Thur. 6. Mr. Symonds' and Dr. Pitt's Take-in commences. (Messrs. Smith and Rippmann.)

Fri. 7. Test Exam. for Revision Classes (Final L.D.S.)

OUR readers will hear, with much regret, of the death of Lady Stevenson, which took place on the 17th inst., after a somewhat protracted illness. The deceased lady was loved and respected by all who had the honour of knowing her, and the kindly interest which she has always displayed in this institution was but a single phase of her many charitable actions. We extend our most sincere condolence to Sir Thomas and his family in their recent great loss.

Passim.

THE recent libel suit brought against the *Lancet* has been followed with great interest by all. The verdict given against the *Lancet*, no doubt, came as a surprise to many; notice of appeal, however, has been lodged, and we refrain from remarking on this verdict until the case is definitely settled. One point which this case does bring out, and vividly illustrates—a point of interest to all medical and dental practitioners—is the march of patent medicines, and the danger which might occur by the use of drugs sold under proprietary names that convey no information as to the nature or composition of the suggested remedies. Many practitioners have been faced with what are almost insurmountable obstacles in the carrying out of their prescribed treatment. We refer to those patients who, in spite of all advice and entreaty, persist in taking some patent medicine with a fancy name in preference to, or at the same time as, that prescribed by the physician. This patent drug may be of such a composition that not only is it diametrically opposed to the rational treatment, but also extremely harmful in itself. An attempt to remedy the misuse of these proprietary compositions has been made by the publication of the British Pharmaceutical Codex, a book produced by the authority of the Pharmaceutical Society, which defines a great number of the so-called proprietary drugs. Nevertheless, the popularity of many of these mixtures is so astounding and far-reaching that often practitioners will find it difficult to remove their patient's fixed idea that Such-and-Such's mixture is the true panacea of all evils.

IN the Colonies, where the distances are so great and the towns so scattered, patent medicines are greatly in vogue, and wonderful and weird are the many uses to which the panacea is put: everything, from contusions to epileptic fits, is treated with the Universal Elixir. This rather calls to mind the dear old skipper, in the days when even the largest vessels carried no surgeon, who used to treat all ailments himself. The medicine chest was numbered in such a manner that each compartment contained the drug to be given for the symptoms complained of. For example: No. 1, Headache; No. 2, Diarrhœa; etc. During one long voyage one of the sailors developed "fits." The skipper immediately sought his medicine chest. Partition No. 14 was labelled "Fits," but, alas! it was empty. For a second the old man was nonplussed, but an inspiration struck him; he mixed Numbers 8 and 6, and administered the result. History does not relate the sailor's subsequent fate.

DR. GEORGE TURNER, who left us in 1895 to undertake the duties of Medical Officer of Health for Cape Colony, is once more back in the old country, having retired, his tenure of office terminating under the Civil Service age limit. Dr. Turner has had an exceptional career, and the general regret expressed on all sides on his retirement shows that his magnificent efforts have been appreciated. At the exceptionally young age of 23 he was appointed to the important post of Officer of Health for Portsmouth—an appointment which speaks volumes for his ability and knowledge of matters pertaining to public health. Later he occupied a similar position for Herts and Essex, combined counties, and at that time was our lecturer on hygiene, and an examiner on the Conjoint Board. Whilst Health Officer in Cape Colony he did yeoman work in the curing of the all-devastating rinderpest. It is calculated that he saved the Colony something like six millions sterling in this way. At the leprosy station at Robben Island he rendered valuable aid, and studied the dread disease in all its shapes.

IN 1900, when dysentery and typhoid fever were scourging our Transvaal army, Lord Roberts applied to the Cape Government for the assistance of Dr. Turner, and he went as Sanitary Adviser to the Forces. In 1901 he became Officer of Health for the Transvaal, and till 1904 was busy fighting the rinderpest from his "serum factory" at Daspoort. In 1904 he conducted the census of the Colony and Swaziland—a work remarkable for its comprehensiveness, and historical in that it was the first thorough enumeration of the people of the Transvaal. We trust that Dr. Turner will live long to enjoy his well-earned pension, and we join his host of friends and admirers in wishing him every happiness.

THE latest dispatch from the field of action in the great anti-rat war, tells that the rodents have already shown signs of diminishing in numbers. Though there have been relatively few cases of the Plague reported in Great Britain, nevertheless it is highly commendable that prophylactic measures should be undertaken. The rat serves no useful sphere in our economic system, none the less it has been surprising, in these days of faddists and Anti-everything Societies, that no word has been raised in his defence. One has but to peruse the reports of the various Plague Commissions to realize the importance of the "Mus decumanus" as an infective agent. During all epidemics the mortality amongst the rats was increased coincident with the epidemic amongst man; even in the sporadic cases there was noticed a sporadic outbreak in the world of the rodent, and most observers state that the epizoötics invariably preceded the epidemics. At many places, however, plague amongst the rats has not been accompanied by human epidemic, and *vice versa;* nevertheless the association on so many occasions of the two forms of the disease are sufficient, we think, to warrant a general destruction of the useless vermin.

AN old Guy's man, who has rendered great service in the investigation of the Plague is Dr. Burnett Ham, Commissioner of Public Health for Queensland. His extensive work is embodied in the Report issued to the Houses of Parliament of that Colony. The thoroughness with which Dr. Ham has dealt with the various outbreaks of Plague "down under" is almost remarkable, and

his contribution will be a welcome addition to current Plague literature. We congratulate Dr. Burnett Ham on his excellent effort.

WE are pleased to hear that Mr. K. H. Digby, who is warded in Stephen with pneumonia, is making satisfactory progress. Mr. H. J. Smith has undertaken his duties as Mr. Symonds' H.-S. We trust that Mr. Digby will have a rapid and complete recovery.

DR. WEDD, who has been appointed Bacteriologist to the Royal Ophthalmic Hospital, left us on Wednesday last. Mr. A. N. Leeming has been appointed Assistant in the Bacteriological Department in his stead.

MR. BERGEN, Ophthalmic Registrar, is leaving us for two months only. Mr. Clifford Mayer, at present Ophthalmic H.-S., has been appointed Locum Tenens. Mr. A. S. Morton Palmer is the on-coming House-Surgeon in the Eye Wards.

THE New Out-patient Department is already in course of erection, the Newcomen Street end of Hunt's building resounding daily with the sounds of hammer and saw. How considerably the outer aspect of Guy's has changed of late years, was well exemplified the other day, when an old Guy's man paid us a visit. At first he was rather inclined to cavil at the great change, especially when he sought the old Museum, but this mood changed to one of surprise and demonstrative admiration when he was shown the new palatial resting-place of the "specimens." A happy smile of recognition broke over his face, however, as he was leaving, when, encountering a somewhat truculent and gory inebriate between two stalwart constables, he murmured, "Well, that hasn't altered much, anyhow."

MUCH interest is still being displayed in the new "ferment" treatment of cancer. Doubtless, many of our men, in practice, have treated, or are treating, cases by this method. We would be pleased to publish at any time descriptions or notes on the result of their efforts.

IN another column will be found a notice of the approaching Dance given by the Residents. Everything points to a delightful evening, and we would strongly advise those who have not yet obtained tickets to do so at once. The tickets—12s. 6d. Gentleman's, and 10s. 6d. Lady's—include, besides the usual bouffet supper, a supper to be served in the Metropole Restaurant. The rooms themselves are ideal for a function of this sort, and we trust that this year's attendance will be a record one.

UNDER the Sports heading will be found the Inter-Hospital Cup Tie draw. We have a splendid record this year—Guy's is the only first-class team in England which has a clean slate. So it will be unnecessary to exhort our players to train and keep fit, for, apart from holding the Cup this side of the river, they must endeavour to maintain their unique record. We have still strong teams to meet in Oxford University and Plymouth. The results of these matches will be looked for with great interest.

As will be seen, the form of application for the Residents' Theatrical Souvenir is again inset in this issue, so that those who have not yet subscribed may have another opportunity. Many, no doubt, who intend to subscribe have inadvertently postponed sending in their applications; we would ask them to do so immediately, as the first edition is already almost subscribed. Those whose duties bring them to the hospital need not trouble to purchase postal notes, but with the enclosed cash the form may be left with the college porter. Copies may be seen by the end of the month by applying to the Librarian, or at the College Lodge, whilst nurses desiring to inspect one will find the same in the Matron's office.

WE would remind our readers that the subscription of twelve shillings and sixpence to the Clubs' Union for the GAZETTE and REPORTS fell due on the 1st instant. The subscription to the GAZETTE alone, seven shillings and sixpence, is also due, and cheques and postal orders should be made payable to Mr. C. H. Wells, Guy's Hospital, and forwarded as soon as possible. An index and a title-page for the volume just completed have been prepared, and may be obtained from the Librarian. Subscribers can now have their sets of the GAZETTE bound for one shilling and sixpence a volume by leaving them with the Librarian. The binding is in two shades of blue cloth—navy blue or a lighter tint—with the arms of the hospital in gold.

The Residents' Theatricals Souvenir.

THE First Edition of this Souvenir is almost already subscribed, and it is hoped that it will be ready for distribution about the end of this month.

For the convenience of those who have not already sent in their applications, we are again including, as an inset to this number of the GAZETTE, a form which should be filled in and returned **as soon as possible**. Students may obtain these application forms from the College Porter, and when filled in, with enclosure (Postal Notes are **not necessary**), may be left with him, addressed to the Editor.

Nurses may obtain forms from Miss Smith, Matron's Office, and may leave the signed application, with the enclosed cash, with her.

We are pleased to chronicle the interest displayed by old Guy's men, and trust that present students will avail themselves of the earliest opportunity of obtaining one of these elegant little Souvenirs.

We beg to acknowledge receipt of applications from the following :—Drs. Pavy, Pye-Smith, French, Hertz, Eyre, B. Jones, Cameron, Messrs. Symonds, Golding-Bird, R. P. Rowlands, Mrs. Lane, Misses Forsaith and Ray. Sir Cooper Perry, Sir Samuel Wilks, Messrs. Barber, Boycott, Burghard, Braithwaite, Bligh, Butt, Bryant, Bowen, Brookhouse, Barrs, S. Brook, Chase, N. Cox, W. Cock, D'Arifat, L. T. Dean, Daw, Edwards, C.W. Greene, Holman, Hughes, Hole, Jan Mahomed, C. E. M. Jones, Lees, Macalister, D. Mitchell, P. Munden, Minett. May, M. D. Price, Telling, Trethowan, Shaw, Stebbing, Spriggs, Wyatt Smith, Vandermin, Wallis, R Watson, T. N. Wood.

Guy's Physiological Society.

Dr. Boycott presided at a meeting held on January 20th. A paper was read by Mr. C. D. Killpack on "Existing Evils."

Individuals are thoughtlessly led to abuse their rights and privileges owing to an incomplete atrophy of the tendency to evil-doing present in the child. The greatest evil of the present day is our old friend alcohol, which holds its own against all comers; but in discussions on this subject there is frequently a confusion of cause and effect. Apart from the direct effects of alcohol there are many attendant evils in connection with its traffic. Overcrowding is responsible for serious moral and physical evils, and obviously drastic measures are needed to remedy this state of affairs. The indiscriminate enforcement of school attendance has caused a great deal of mischief in many instances. The marriage of consumptive individuals should be prevented by the State, in spite of the cry of sentimentalism which would arise. The usual verdict passed at a coroner's inquest, "Suicide whilst of unsound mind," is a result of the eagerness of the average juryman to get back to his daily occupation as soon as possible. The love of sensationalism evidenced by the British public is most deplorable; it is a pathological condition against which education should exert any influence it may have. These are but a few of our present-day evils; amongst others are "Free Consultations," the abuse of our hospitals by the public, Poor Law administration, late marriages, the abuse of exercise, especially by the fair sex, the indiscriminate use of anæsthetics, and the tendency to use physiological language at this society.

Dental News.

OUR late Dental House-Surgeons, Messrs. Visick and Dear, left the Hospital on January 1st, on conclusion of their term of office. One may say that no more popular or efficient men have held the appointment in recent years; both were liked and respected not only in the Dental Department, but also throughout the Hospital. Our best wishes for the future go with them.

In Mr. Visick we also lose our Dental Correspondent. He has ably filled the office during the past year.

The new arrangements for running the Dental Department, which have now been in force for nearly three weeks, appear to work well, and to be satisfactory both to the student, staff, and to the dressers.

Since No. 9 Room in Out-Patients has been used by the eye-surgeons it has received a great influx of electric light: this is so convenient on dark days that men wonder it was not installed before.

The following dates should be noted by those concerned:—

The first Test Examination for May L.D.S. will be held on Friday, February 7th.

The Dental Society's Dinner on Saturday, February 22nd, as usual, at the Trocadero, the President, Mr. F. J. Pearce, in the chair.

Revision Classes for the Final L.D.S. start on Tuesday, February 25th.

Since Mr. Hunt's appointment as Assistant Curator in the Gordon Museum, he has thoroughly cleared out and re-arranged the specimens in the Dental Section.

The value of the Museum to men in their reading cannot be over-estimated, and it is to be regretted that more advantage is not taken of the opportunities afforded for learning at first hand from the specimens, pathological and others.

Notices.

RESIDENTS' ANNUAL DANCE, FEB. 7TH, WHITEHALL ROOMS, HOTEL METROPOLE, W.C.

Those who have not yet obtained tickets may do so on application to any of the Residents.

Early application is requested, to facilitate the arrangements, etc.

Price of tickets: Gentleman's 12/6, Lady's 10/6

The Eighth Lees and Raper Memorial Lecture will be delivered at the Town Hall, Oxford, on Tuesday, February 4th, at 8 p.m., by W. McAdam Eccles, Esq., M.S., F.R.C.S. Subject: "The Relation of Alcohol to Physical Deterioration and National Efficiency." The lecture will be illustrated by lantern slides. Chairman: Prof. William Osler, F.R.S., etc. Invitation cards may be had on application to John Kempster, Esq., 20, Tothill Street, Westminster, S.W.

FINAL CONJOINT EXAMINATION, MARCH, 1908.

The Test Examination for the Revision Classes in Medicine will be held on Monday, 3rd February, at 10 a.m.

Pupils' Physical Society.

A MEETING of this Society was held in the College on Wednesday, the 16th instant, Mr. E. P. Minett being in the chair. Twenty-two members were present.

Mr. Lee Atkinson read a most interesting paper entitled, "A Theory of Cancer," which was followed with the greatest interest.

All Mr. Atkinson's conclusions were evolved by a most careful line of reasoning. The fundamental points in his theory were argued out by him two years ago, before Ribbert's work was well known in England (and certainly before it was known to Mr. Atkinson), and are found to run along very similar lines. Mr. Atkinson would like to make some change in the blood-state responsible for the abnormal cell-growth that we call cancer.

The Chairman, after thanking Mr. Atkinson for his most excellent paper, opened the discussion, in which the following members also joined: Messrs. Cameron, Cooper, Mandel, Mitchell, Welchman, Reynolds, Ball, and the Secretaries. The meeting adjourned at 9.30 for coffee.

The next meeting is on February 1st, in the Wills Library, when pathological specimens will be shown, Mr. Rippmann in the chair.

Some Extracts from an Address delivered by Dr. Scott Skirving to the Medical Society of the University of Sydney.

(Continued.)

WORLDLINESS.

The term "man of the world" to my mind has often rather a sinister meaning, so I have been at some pains to speak of the physician as being rather in and knowing the world, than of it.

Nevertheless, worldliness of some sort must shape our actions if we are to travel far upon the course in which we are all too apt

"To lose sight of the sun
In the dust of the racing chariot."

Happily, however, the nature of our profession, above all others, will save us from becoming very worldly-minded, "even as others are," to quote the Pharisee.

To begin with, the getting and handling of money, as an object of our lives, pure and simple, can never be the be-all and end-all of our endeavours, as it most certainly is in a large number of other occupations. Our minds must run mainly on the recognition of disease and the attempt to cure—a nobler mental atmosphere than the mere exchange of commodities.

Moreover, few of us are likely to be corrupted by great riches, for vast wealth seldom, or never, comes to the disciples of St. Luke. And the very impossibility of much money keeps us from making its acquisition the conscious ever-present object of our labours.

I take pleasure in repeating to you the well-known words of R. L. Stevenson:—

"There are men and classes of men," he says, "that stand above the common herd, the sailor, the soldier, the shepherd not unfrequently, the artist rarely, rarelier still, the clergyman, the physician almost as a rule . . . generosity he has, such as is possible to those who practise an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments, and, what is more important, Herculean cheerfulness and courage."

I never read these lines without pride and some small desire to deserve their praise.

ON TACT, SECRECY AND DISCRETION.

You will notice how deftly Stevenson touches the points in medical character which are needed in the good physician. TACT—Yes, Gentlemen, the wisdom not to hurt by careless speech. SECRECY—To hold inviolate the secular confessions of the consulting-room. SYMPATHY—DISCRETION—What a lay sermon might not be preached on such texts!

As examples of want of tact and discretion, I instance the following:—"I often hear foolish persons, medical and otherwise, in various tones of voice greet some seedy, neurotic patient (who probably is ill enough, but would fain think he is not) in the following fashion. Instead of silently appreciating the patient's ill look, these

tactless ones exclaim: "Dear me; you do look ill. Whatever has come over you?" I have the strongest objection to this type of ass. I have known actual harm done to nervous patients by such speech.

Again, there is another foolish one who rises to a bad eminence in indiscretion by interrogating the sick husband as to his venereal history in his wife's presence. However virtuous the patient's past has been, he is not likely to wish to discuss it in the presence of his wife.

On the graver violations of the obligations of secrecy as to the concerns of our patients, I have nothing to say here. You all know that you must hold your tongues if you are to retain the confidence of your patients or your own self-respect. It is against smaller tattlings that I warn you. One is so apt in the freedom of social life to say things about patients which had well be left unsaid, and the ever captious public at once lay hold on these small slips of speech, distort and magnify them, so that soon you hear that Dr. So-and-So tells people about his patients. Try, then, to avoid this pitfall,

When I speak of sympathy, I mean the power to fall and enter into the sorrow and embarrassments of your patients. It is a depressing thought that we make our living out of the misfortunes of our fellows. Let us, then, "temper the wind to the shorn lamb" as much as we can, not only in kindness of thought and speech, and touch, but in the reward we ask for our own services. Please do not misunderstand me. The labourer in medicine is mostly worthy of his hire; and the patient, when he gets well, is mostly inclined to think that he is overcharged (may Heaven forgive him!!) because he has not bought goods or chattels which he can handle or show for his money.

The laity as a rule do not follow altruistic occupations; and we must not expect too much from them. But what we sell is often more valuable than much fine gold—and we have to live—therefore we must be fairly remunerated. I merely ask you to think with me that those who are really badly off, whose earnings cease with the enforced idleness of the breadwinner, and who have no nest-egg laid by, are the class to whom our professions may exercise a large-hearted charity, and "let-down easy."

To the rich not excessive, but just the full value of our services.

Of Other Worldliness and the True Object of Our Lives.

A great Elizabethan tells us that, "as we are debtors to our profession, so ought we, by way of amends, to be a help and an ornament thereunto." The injunction is good, and I glory in the long list of men such as Harvey, Hunter, Bright, Addison, or Lister, who have adorned the age in which they lived, and the profession they advanced so greatly. But it is not given to many to be epoch-makers in medicine. Few are chosen to that high mission.

Natural ineptitude, lack of means or suitable environment may hide some unknown Koch or obscure Simpson of our profession. Yet to all of us is given the chance of doing something, however small, apart from the common drudgery of practice. An isolated fact, correctly recorded and communicated to others, a series of cases under one treatment, the surroundings of an epidemic, all such observations and experiences may help others in the search for wider issues. The first ovariotomist was a country practitioner, so also was Edward Jenner. In doing small things well and faithfully, we may unknowingly be helping someone with ampler brains and opportunities to some great discovery:—

"For not by Eastern windows only,
When daylight comes, comes in the light,
In front the sun climbs slow, how slowly,
But Westward, look! the land is bright."

To us, Gentlemen, of all men, to us who behold so often the miracle of birth and death, who daily witness the tragedy of human life, its physical sufferings, its mental anguish, and its unattained desires, sombre thoughts must often come. "The maddening mystery of creation," and the unsolved riddle of the future, must arouse questionings which are surely present with us in our daily work, and colour our thoughts and actions. Whether our souls are made happy by the anodyne of religious faith, or whether we grope reverently, seeking light, one thing remains sure, that the end and object of each of us as individuals is to do our duty as it lies at our door.

"Live on, brave lives chained to the narrow round
Of Duty, live, expend yourselves, and make
The Orb of Being wheel on steadfastly
Upon its path—The Lord of Life alone
Knows to what goal of Good—Work on—live on!"

Let us, then, see to it that we learn our profession well and thoroughly, and practise it with honour, and honesty, with kindliness and sympathy.

Let us grant that it is often a rather sad world in which we live, yet the mellowing effect of years teaches us also how much less sad it may be made by the exhibition of those qualities which cost us very little by tolerance, unselfishness, and speaking no evil of others.

The good which flows from these virtues "does not pass away with years, nor any death dispraise."

"This is the way of salvation," said Marcus Aurelius, 'To look thoroughly into everything, and see what it really is, alike in matter and in cause, with your whole heart to do what is just, and say what is true: And one thing more, to find life's highest fruition in heaping good so close, that not a chink is left between."

This and much else that I have just said may be a counsel of perfection, impossible of performance. Nevertheless, the great Emperor's ideals remain to-day just as true, and by striving after them we shall, perchance, with many stumbles and slips, come nearer to—

"That choir invisible
Whose music is the gladness of the world."

Papers by Guy's Men.

A Case of Double Popliteal Aneurysm. By W. H. Jalland, D.L., J.P., F.R.C.S.—*British Medical Journal*, 11th January, 1908.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Weymouth and District Medical Club.

DEAR SIR,—The Weymouth Medicos' Club, noticed in Passim of yesterday's GAZETTE, is not quite original, for we started exactly such a club at Woking in February of last year. It has, as you expect, been a great success. We began with an annual dinner—a good beginning—and our meetings have been most successful. We discuss most things, except religion and politics, which are barred—from the Cottage Hospital, Woking, to whiskey, and from cerebral tumour to tobacco, and we always manage to be unanimous. Only two out of our twenty-five eligible members have failed to turn up at, at least, one meeting—one of those, I am sorry to say, one of three Guy's men. One good result has been, I fancy, that we each have found the "other fellows" much better fellows than we ever suspected they were. A paper, volunteered, is always welcome and always interesting. The full moon decides our nights of meeting, for the convenience of outlying members, and our only difficulty has been as to breaking up, which is usually not until the iron tongue of midnight has struck twelve. So that, paradoxical as it may appear, though we do not meet till after dinner or separate till early morning, we may yet say truthfully with the poet— "'Tis ever morning when we meet,
Night when we say good-bye."

—Yours truly, F. WYATT-SMITH.

Briarwood, Woking, January 10th, 1908.

"Rheumatic Pneumonia."

DEAR SIR,—With regard to Dr. Theodore Fisher's letter in the GAZETTE of the 28th December, in one of the two cases I quoted—that of the man T. W.—it was his first attack of acute rheumatism, and, as far as we know, there was no evidence of previous cardiac disease. It cannot, therefore, I think, be designated an example of pneumonia associated with cardiac disease. In the case of the girl, although there was previous cardiac disease, during the pneumonic attack, there were practically no signs of heart failure.—I am, Sir, yours truly,

A. A. GREENWOOD.

The College, Guy's Hospital, S.E.

Old Prints.

DEAR SIR,—I have in my possession some prints of ancient medical men, Sydenham, Willis, Malphigius and Joannes Brown. Could you or any of your readers give me any information regarding the originals?—Obediently yours, E. L. W.

[There are several publications on "Old Prints," but E. L. W. may learn all he requires to know on application to Print Department, British Museum, or from one of the West End art publishing firms.—ED.]

Change of Address.

Dr. S. H. Cummings Air, from Guy's Hospital to 205, Selhurst Road, South Norwood, S.E.

Dr. J. Dell Bridger, from Butterworth, Transkei, to Kei Road, Cape Colony.

Lieutenant Brooke Churchill, R.A.M.C., from Chakrata to Meerut, India.

Dr. L. S. H. Glanville, from Guy's Hospital to North Street, Emsworth, Hants.

Mr. F. G. Goodman, L.D.S., from Clarendon, Topsham, Devon, to 44, Southernay West, Exeter.

Dr. E. M. Harrison, from Guy's Hospital to Wentworth House, New North Road, Huddersfield.

Dr. Percival C. P. Ingram, from St. George's Infirmary, Fulham Road, S.W. to Shoreditch Infirmary, Hoxton Street, N.

Mr. J. Kennerley Pedley, L.D.S. Eng., from 3 to 7, Mount Sion, Tunbridge Wells.

Dr. George Pinder, from 29, Cedar Street, Southport to Sunny Dell, Cronkbourne Road, Douglas, Isle of Man.

Dr. W. Woolfe Read, from Shoreditch Infirmary, Hoxton Street, N., to County Asylum, Littlemore, Oxon.

Mr. E. G. Robertson, L.D.S. Eng., from Guy's Hospital to 28, West Southernhay, Exeter.

Dr. C. D. Pye-Smith, from Belgrave House, Huddersfield, to Wentworth House, New North Road, Huddersfield.

Mr. John Stevens, L.D.S. Eng., from 16, Springwell Avenue, Harlesden, N., to Knottsall, Ealing Road, Wembley, Middlesex.

Dr. W. Bramley Taylor. J.P., from 145, Denmark Hill, S.E. to the Birches, Weybridge Common, Surrey.

Mr. Hedley Visick, L.D.S. Eng., from Guy's Hospital to 115, Harley Street, W.

Mr. Hubert C. Visick, L.D.S. Eng., DD.S. Penn., from 140, Harley Street, W., to 39, Brook Street, W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

From the Gazette's Special Pathologist.

NOTICES.

R. F., MANCHESTER.—This is a simple mucous polypus of the rectum. It has the usual adenomatous structure consisting of mucous glands in a connective tissue stroma. The latter is infiltrated with leucocytes, as if the tumour had been partially strangulated before being broken off its pedicle. It is not a malignant growth.

G. M. J., ALTON.—This specimen of sputum contains a little muco-pus, but no tubercle bacilli are found.

PATHOLOGIST.

Pass List.

UNIVERSITY OF LONDON.—M.D. Examination, December, 1907.—Incompletely reported in previous issue.—C. E. Iredell, B. A. Richmond (University Medal), E. B. Smith, M. de Lancey Robinson.

UNIVERSITY OF OXFORD, December, 1907.—Final M.B. Examination.—Pathology and Forensic Medicine and Public Health: N. Flower (Exeter). Medicine, Midwifery and Surgery; C. G. Douglas (Magdalen).

UNIVERSITY OF CAMBRIDGE, January, 1908.—Degree of B.S. Conferred: J. H. Ryffel (Peterhouse).

SECOND CONJOINT EXAMINATION, January, 1908.—H. W. Doll, W. S. Lacey, D. C. Lloyd, M. M. Munden, E. A. Penny, J. Pryce-Davies, A. H. Todd, J. W. Williams.

FIRST CONJOINT EXAMINATION, January, 1908.—Part I. Chemistry. Part II. Physics.—*A. Abd-el-al, R. B. Campion, C. A. R. Gatley, J. L. D. Lewis, V. A. Luna, W. A. Thompson. Part III. Elementary Biology.—C. A. R. Gatley, L. P. Harris, G. B. H. Jones, V. A. Luna, M. Pern, G. B. Pritchard, W. A. Thompson, W. C. Whitworth.

* Passed in Part I. only.

PRELIMINARY SCIENCE (L.D.S.) EXAMINATION, January, 1908.—R. R. Adams, *T. L. Fiddick, S. W. Ingram, H. Thornton.

*Passed in Physics only.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in the Medical Wards—Messrs. W. Johnson (Dr. Hale White); F. Morres (Sir Cooper Perry); C. D. Roberts (Dr. Shaw).

Clinical Assistants in the Surgical Wards.—Messrs. C. H. Mills (Mr. Golding-Bird); L. T. Baker (Mr. Dunn).

Ophthalmic Dressers.—Messrs. M. E. Ball, L. T. Dean (February 1st) (Mr. Eason); R. P. M. Roberts (Mr. Ormond).

Surgeons' Dressers.—Messrs. A. E. Rayner, L. Bromley, F. Kahlenberg, H. F. Percival (Mr. Golding-Bird); W. T. Clarke, C. F. Searle, C. A. Wood (Mr. Symonds); J. L. Atkinson, G. F. Haycraft, A. A. Greenwood (Mr. Lane); M. M. Adams, V. T. P. Webster, J. R. Perdrau, H. L. Duke (Mr. Dunn).

Clerks in the Light Department.—Messrs. T. Stansfield, S. H. Browning.

Pathological Assistant to the Surgical Registrar.—Mr. F. J. Wheeler.

Obstetric Dressers.—Messrs. R. A. Rankine, F. J. Wheeler, H. A. Sanford (Dr. Horrocks); C. M. Plumptre, H. B. Kent, V. Townrow (Mr. Targett) (March–April).

Externs.—C. M. Plumptre, H. R. Bastard, V. Townrow, J. Walker, H. A. Sanford (February); A. H. Crook, A. D. J. B. Williams, C. C. Holman, D. C. Druitt, F. R. L. Atkins (March); S. H. Browning, T. Stansfield, H. C. Lucey, T. F. Brown, H. I. Shahin (April).

Nursing News.

MATRON'S OFFICE.

Sister Amy (Miss A. H. Clarke), who was appointed Sister in December, 1904, left the Hospital on January 1st, 1908. Miss Dorothy Woodward (Sister Dorothy), who has been acting as Second Home Sister since July last, has been appointed to succeed Miss Clarke as Instructress in the Preliminary Training School, and Miss Ethel Clifford, who completed her three years' training in June last, and has since been Staff Nurse in the Light Department, has been appointed Second Home Sister.

On December 4th, 1907, Nurse Mayes left the Hospital on completion of her three years' training to take up private nursing, and Probationer Miller was appointed to succeed her as Head Nurse in Bright Ward.

Nurse Rennison, Head Nurse in Naaman Ward, left the Hospital on December 9th last, and Probationer Zagallo was appointed to succeed her as Head Nurse.

Nurse Cockin left the Hospital on December 6th last on completion of her three years' training, and Probationer Humphreys was appointed to succeed her as Head Nurse in Dorcas Ward.

Nurse Hyde, Head Nurse in Lydia Ward, left the Hospital on December 12th last, on completion of her three years' training, and Probationer A. M. Ward was appointed to succeed her as Head Nurse.

On January 8th, Nurse Greenall left the Hospital on completion of her three years' training, and Probationer La Touche was appointed to succeed her as Head Nurse in Miriam Ward.

On January 10th, Nurse Lyons, Head Nurse in Queen Ward, left the Hospital, on completion of her three years' training, to commence her training in midwifery, and Nurse Cornell, Head Nurse in the Isolation Wards, was transferred to Queen Ward.

On January 15th, Probationer Walsh was appointed Head Nurse in the Electrical and Light Department.

The following Probationers have been successful in passing the Examination in Medicine held in December last:—

Probationers Allen, Aston, Barker, Bell, Bingham, Bishop, Blair, Blenkarn, Browne, Carey, D., Carey, M., Carter, Charlesworth, Clifford, Cochrane, Collingwood, Cruickshanks, Dean-Smith, Dudding, Dulake, Dyment, Fisher, Forsaith, Foxon, Fraser, Gabriel, Gill, Gray, Grinsell, Hepburn, Howe, Hunt, Jefferson, Keays, Kenny, Kerr, Kingzett, Krauth, Latcham, Leach, Leigh, Lucas, Lustic, Lumholtz, Lowe, McMorland, McKitrick, Marsh, Mather, Mawson, May, Molesworth, Moore, Morgan, Moss, Myers, Nixon, Norman, Nelson, Oliver, Phillips, Prescott, Price, Quilter, A. Rees, G. Rees, C. Rose, Salmon, Sandeman, Shaw, Skinner, Sladen, Smith, Spence, Stewart, Sutton, Sweet-Escott, Turner, Tyers, Vanes, Vine, Wallis, Ward, White, Whittam, Willcox, Woollett, Worsley.

Inherited Syphilis.

The Opening Address to a Discussion before the Society for the Study of Disease in Children, Nov. 13th, 1907.

By R. CLEMENT LUCAS, B.S., M.B. Lond., F.R.C.S., Consulting Surgeon to Guy's Hospital.

GENTLEMEN,—I have had the honour of opening this discussion thrust upon me by the unanimous vote of the Council as a penalty for certain criticisms I ventured to make on former discussions, to the effect that the length and learning displayed in the opening addresses—sometimes five or six in number—left neither time nor opportunity for subsequent debate. I ventured to think the opening should be more suggestive than dogmatic, and terse rather than discursive. As a consequence, I am here to represent a phase rather than a faculty, and the burthen of presenting new ideas and new facts will rest almost entirely with those who follow.

To begin with, this discussion will open under quite different circumstances to what it would have done had it been held three, or even two years ago, for it is now generally accepted that the *Spirochaeta pallida*, discovered by Schaudinn and Hoffmann in 1905, is the true cause of the disease, and that mercury, formerly given empirically, is a direct antidote by causing destruction of the parasite.

THE NAME.

This leads me to say a word or two on the three terms applied to this form of the disease. 1. Congenital. 2. Hereditary. 3. Inherited. Of these three I greatly prefer the third. *Congenital*, besides being objectionable in form and suggestion, is not universally true. *Hereditary* suggests something that may be passed on indefinitely, of which there is no proof; whilst *Inherited* implies only something derived from the parents which is detachable, like a fortune or misfortune, and this more correctly expresses the passing on of the *Spirochaetae* to the offspring.

THE MICRO-ORGANISM.

The cause of syphilis, whether inherited or acquired, is the presence in the blood and tissues of the same organism, which can be demonstrated in the various secondary lesions, in the blood, and in the internal organs.

The *Spirochaeta pallida* is a protozoon of spiral form 4 to 20 μ. in length (about half to three times the diameter of a blood corpuscle) and $\frac{1}{4}$ μ. in diameter, with a flagellum at either extremity. It is very motile, and its motility is of three kinds—a lashing, cork-screw, and a to-and-fro movement. It stains pale pink with Giemsa's fluid, whilst the coarser, highly refracting *Spirochaeta refringens*, with which it is often associated, stains dark purple.

THE MODE OF TRANSMISSION.

The discovery of the cause of the disease necessitates the re-arrangement of our former views as to its transmission. Those who remember the revolution in thought caused by the discovery of the tubercle bacillus—how that the long-taught diathesis gradually receded into the background, and the danger of contagion by inter-communication in houses and families, grew into importance—will be prepared for some change of idea in reference to syphilis.

To my mind, inheritance from the father alone is now put entirely out of court, and it follows that infection of a mother by her syphilitic fœtus can never occur. For how is it possible that a *Spirochaeta* which is highly motile, and whose length averages rather more than the diameter of a blood corpuscle, can penetrate an ovum $\frac{1}{200}$th of an inch in diameter and multiply without destroying it? I lay it down as an axiom, to be demolished, if you will, by discussion, that *inheritance is invariably through the syphilised mother.*

This is supported by Colles's law, that a syphilitic infant cannot cause a chancre on the nipple of its mother when suckling.

It would seem that, when virulent, the *Spirochætes* penetrate the chorion or placenta and occasion miscarriages, macerated fœtuses, or premature births; but when the virus is attenuated by time or treatment, the placenta forms a complete protection to the developing fœtus, and it is the separation of the placenta at birth, which allows the infection to take place through the umbilical vein. Hence the regularity of the secondary exanthematous stage from a fortnight to three months after birth. *In these cases the separation of the placenta is the first stage, and corresponds to the chancre of acquired syphilis.*

COLLES'S LAW.

I alluded to Colles's law (which was first stated in 1837) in support of the argument that the woman was always first syphilised before the embryo or infant. The law is that a woman giving birth to a syphilitic infant cannot be inoculated with syphilis by the infant when she is suckling it; in other words, though the

mother may have shown no definite signs of syphilis, she is immune; whereas the syphilitic infant put to the breast of a healthy woman may inoculate her nipple and convey syphilis to her.

Hitherto, Colles's law has been used as an argument in support of the view that the mother may get a mild form of syphilis from her syphilitic fœtus, whose syphilis is supposed to be derived entirely from the father. But the law of immunity will remain equally true if it be supposed that the mother is first inoculated by the father, a large dose of the protozoon causing an obvious eruptive syphilis, and a small dose, a syphilis which misses the eruptive stage.

Syphilis in a man is generally admitted to be capable of transmission to a succeeding generation for a much shorter time than syphilis in a woman, and this supports the view I have stated, viz., that for transmission it is necessary that the woman be first infected.

TRANSMISSION BY MILK.

The question whether the milk of a syphilitic female may infect a healthy infant at the breast has been discussed for two and a half centuries, since Ambroise Paré, in the seventeeth century, quaintly observed: "Infants suckled by syphilitic nurses are infected by them, seeing that the milk is nothing but whitened blood, which, being infected by the virus, the child fed with it imbibes the same qualities." Hunter, founding his argument on ineffectual attempts to inoculate the blood of a syphilitic person, came to the conclusion that not only the blood, but every secretion derived from it, such as milk, saliva, perspiration, &c., could not convey the disease. But his experiments were inconclusive, and his deductions incorrect.

Pellizzari succeeded in inoculating the blood of a syphilitic person, and if Voss' experiment is to be trusted, milk has been directly inoculated also.

A remarkable case bearing on this subject I showed before the Royal Medical and Chirurgical Society in 1881, and it is republished in the January number of the *British Journal of Children's Diseases*. A woman, aged 30, gave birth to a healthy child on December 11th, which she suckled. The following Easter her husband inoculated her with syphilis, but she continued to suckle the child. She consulted me three months later, when suffering from severe secondaries, squamous eruption, sore throat, condyloma and loss of hair, but the child showed no sign of infection. The mother was then treated with small doses of mercury. She and the child were shown when the latter was ten months old. He had continued to suckle, and remained plump and in perfect health, though the mother still had patches of circinated squamous syphilide on her arms. During the two years the mother remained under my care for treatment the child showed no sign of inherited syphilis. The importance of this case rests on the fact that the mother had suckled her child for three months after her infection before any treatment was commenced, so that it cannot be argued that the infant was taking the antidote in the mother's milk with the poison, and so escaped a source of possible inoculation; but it proves that the milk of a syphilitic woman, when received into the alimentary tract of an infant, need not convey any infection to the child.

TRANSMISSION BY SEMEN.

It is obvious, as the greater cannot be included in the less, that a *Spirochaeta* cannot be carried in a spermatozoon; but this does not exclude the possibility of the *Spirochaetae* being conveyed by the fluid parts of the semen.

The early experiments of inoculation by Mireur failed, but if the recent results obtained by Finger on monkeys be correct, the semen of syphilitic men in the secondary stage is inoculable. It seems almost necessary that it should be so to account for the cases of inherited syphilis conveyed after the healing of the chancre. If the presence of the *Spirochaetae* can be with certainty demonstrated in the semen of men suffering from recent syphilis, much doubt would disappear, and, in the cases where no chancre could be traced in the woman, the probability of the infection being carried through the uterus, after the disintegration of its lining membrane at any menstrual period, would be apparent.

TRANSMISSION TO THE THIRD GENERATION.

Another question much open to discussion is whether syphilis inherited is capable of transmission to the third generation. If the tertiary symptoms, occurring ten or twenty years after inoculation, can be proved to be due to renewed activity of the *Spirochaetae*, in certain situations, there seems to be a fair possibility of their being carried to a third generation. But the question is beset with difficulties, since you must prove the sexual purity of two persons up to the time of maturity, and these are generally persons in whom a tendency to vice is also hereditary, for it is known that a person the subject of

inherited syphilis is not immune from re-inoculation after a certain period.

Hutchinson mentions eight cases that have come under his observation of persons who presented signs of inherited syphilis, and who married, but whose offspring showed no evidence of the disease.

On the other hand, Edmond Fournier collected 116 cases, 59 of which, he thought, were to be relied upon as showing transmission to the third generation, and R. W. Taylor has published others.

Dr. D. M. Hutton brought a case before this Society, which is published in the 1st Volume of our Reports, and is there criticised by Dr. Ashby and others.

My own experience is limited to one case, but it is of unusual importance, as both parents showed most obvious signs of inherited syphilis which were unmistakable. A blind man attended a school for the blind where he met a blind woman, for whom he developed a feeling of affection. They were both blind from interstitial corneo-iritis, and they both presented the typical physiognomy of the inherited disease, notched teeth and scars around the mouth. They married, and at the time the man came under my care their first child was about two months old. The blind wife was brought up to visit her husband, and, seeing she was marked by the same disease, I sent for the infant, which presented no evidence whatever of syphilis, nor did it develop any symptom of inherited disease during the months I was able to keep it under observation. This infant, in whom there should have been double inheritance, showed, so long as I was able to watch it, complete immunity.

THE INFANT MORTALITY.

There is probably no disease responsible for such an enormous destruction of human life in its earlier stages as that caused by syphilitic parentage. But my experience shows that this mortality is greatest in those families where both parents have suffered from chancre, syphilis, and obvious secondaries. The severity of the infection and ineffective treatment, or lack of treatment, are the two factors which determine the mortality. I give two illustrations:—

CASE I.—E. S. had been married eleven years, and suffered three months after marriage from rash and sore throat. The first child was still-born, twelve months after marriage, and was miscarried at the sixth month. The second child lived (the mother being at this time under treatment), but had severe snuffles and rash, is very delicate, and has recurrent sores and eruptions. The third, fourth, fifth, sixth, seventh, eighth and ninth children were all born at full time, but all died from a few minutes to within two or three months of birth. The tenth child was brought up for treatment suffering severely from snuffles, stomatitis, and coppery, shiny eruption. Thus two weak children only were living out of ten.

CASE 2.—R. C., three weeks after marriage, suffered from sores on vulva, followed by rash and sore throat, for which she had no prolonged treatment—a pale, cachectic-looking woman. The first child, ten months after marriage, was stillborn at the seventh month. The second child was prematurely born at the eighth month and lived a day. The third child, born at full time, a fortnight later came out in large brown spots and had snuffles, and was taken to Guy's and treated by blue ointment rubbed in over the abdomen. She still lives, and at the age of eleven shows no notching of incisors or evidence of her inheritance. The fourth child did not come out in an eruption till five weeks old. He died at six weeks. The fifth child, a boy, came out in an eruption at five weeks, and died at seven weeks. The sixth child was stillborn. The seventh child, prematurely born at the eighth month with an eruption upon her, survived a day. The eighth child, a girl, had a rash soon after birth, and died on the eighth day. The ninth, also a girl, was born healthy, but an eruption came out at the third week. She was treated, but died at eleven weeks. The tenth child, a fine boy at birth, came out in an eruption three weeks after birth, and was brought up for treatment. He was suffering from symmetrical squamous syphilide of legs, feet, arms and ears, little on body, ulceration of mouth and buttocks, and severe snuffles. Again two living out of ten.

THE SECONDARY STAGE.

The trite definition that "syphilis is a fever diluted by time," given by the late Dr. Moxon, is applicable to the inherited as well as to the acquired disease.

I argued that the primary stage is the separation of the placenta, and the infection of the infant through the umbilical vein. The secondary or exanthematous stage commences from the second week to as late as the third month. It is characterised by eruptions which may vary from slight brown macular syphilide to pompholyx, by snuffles, stomatitis, condyloma, wrinkled skin and wasting, enlargement of the spleen and liver. Then follow certain changes

in the bones, in severe cases perhaps epiphysitis, giving rise to pseudo-paralysis, Parrot's nodes, causing natiform skull and square forehead, cranio-tabes and bent bones.

It cannot be too strongly insisted on that the moist eruptions, and ulcerations about the mouth and anus, as well as the vesicular skin affections, are charged with the *Spirochaetes* and highly contagious.

From the second to the sixth year there is commonly a rest in the symptoms that are regarded as characteristic, but the tibiæ may become thickened from periostitis, or a joint may become swollen and painful, and resolve under mercurial treatment.

But now the characteristic physiognomy has been gradually formed, the flattened nose, the square forehead, the radiating lines from the mouth, the stunted figure and pallid face; and then, during the second dentition, we look for the three signs pointed out by our great observer, Jonathan Hutchinson, the notched incisor teeth, interstitial corneitis, and syphilitic deafness. Associated with such signs, or occasionally independent of them, gummatous destruction of the soft or hard palate may occur, and ulcerations of the skin and cellular tissue. Destruction of the nasal bones, caries of the forehead and skull, of the long bones and dactylitis may take place as the result of the inherited disease.

MOON'S MOLARS.

The teeth Mr. J. Hutchinson described as so characteristic of the disease are the notched and narrowed incisors, especially the central incisors of the upper jaw. This defect is brought about by arrest in development of the central columella, of which each incisor has three. But I wish to draw special attention to the characteristic change brought about by the disease in the first molars, described by the late Mr. Henry Moon many years ago, since this change has recently been rediscovered both in America and on the Continent. The diagram which I show is taken from the fourth edition of Bryant's Surgery, published in 1884, wherein the article on teeth is written by Mr. Moon. He figures and describes the syphilitic first molar as "reduced in size and *dome* shaped, through the dwarfing of the central tubercle of each cusp." He also contrasts these teeth with mercurial teeth and syphilitic-mercurial teeth. The change in the molar is of some clinical importance, since occasionally it is characteristic when the incisors are normal.

EYES AND EARS.

The eyes may become affected at an early stage by a choroido-retinitis which may leave permanent changes, easily recognised by ophthalmoscopic examination; and iritis, though rare, may occur during the eruptive stage. Interstitial keratitis is most frequent between the ages of six and sixteen, but may occur much later, and rarely earlier. It is highly characteristic of the inherited disease.

Like the eyes, the ears are attacked by different affections in the early and late stages. During the eruptive stage, otitis media may commence as an extension from the inflammation of the naso-pharynx, whilst during the second dentition a progressive deafness of labyrinthive origin may cause complete loss of hearing. Specialists in these departments will, I hope, give us some new facts relative to the syphilitic manifestations in the eyes and ears.

INHERITED SYPHILIS ATTACKING THE VISCERA.

Much work has been done in demonstrating the disease in the various viscera, not one of which appears to be exempt, and there is probably a large field still open here for further investigation. Enlarged spleen and liver associated with rickets may be proved almost invariably to be of syphilitic origin.

The disease attacks the various organs in two forms, as a small cell infiltration, usually following the course of the vessels, which, in its development and decline, may lead to fibrosis and consequent atrophy, and as a gummatous tumour, which is less common.

When the inherited disease attacks both testicles or both ovaries at an early age, and brings about their fibrosis and atrophy, a condition known as *infantilism* is produced at a period when the sexual characteristics should be pronounced.

The physicians present will, I hope, give us much new information on inherited syphilis of the viscera.

THE NERVOUS SYSTEM.

Much difference of opinion exists as to the frequency of nervous disease dependent on inherited syphilis. Whilst some are inclined to attribute every conceivable weakness, paralysis or mental defect to this disease, others regard the nervous lesions dependent on it as infrequent. A certain proportion of epileptics, deaf-mutes and idiots, but not a large percentage, show signs of inherited syphilis. On the other hand, syphilitic endarteritis of cerebral vessels, gummata on nerves, and sclerosis of brain and

spinal cord have been observed by competent observers.

One of the most interesting observations of late years is that some cases of hydrocephalus are dependent on inherited syphilis, and are curable by mercury.

THE NEED OF CRITICISM IN DIAGNOSIS.

In conclusion, I wish to insist on the importance of weighing carefully all the evidence before determining that a particular affection is due to inherited syphilis. Every deformity, from dislocated hip to cleft palate, all defects such as hernia, infantile paralysis of various kinds, and even nævi, have been described by various writers as dependent on inherited syphilis, and as if better to cover the anomalies the term "para-syphilis" has been invented to add to the confusion. I need scarcely waste time in combating such crude generalizations as that "all rickets take origin in syphilis," when any puppy taken from a litter and deprived of proper food and exercise will certainly develop this disease.

Equally crude statements have been made as to other diseases. We do not deny that persons whose constitutions have been weakened by disease are liable to produce degenerates in succeeding generations; but in future the most certain test of the disease being syphilis will be the presence of the *Spirochaeta pallida* in the part affected. This organism has an extraordinary persistency, producing local symptoms after lengthened periods, but happily we have, in mercury and the iodides, drugs which control its development and bring about its destruction.

Metchnikoff has recently shown that some hours after direct inoculation the application of a calomel ointment applied to the sore is sufficient to kill the organism and prevent the occurrence of secondary symptoms.

Gentlemen, I have now finished my brief sketch of this interesting disease as it attacks the second generation. It is the merest outline, that you may fill up the substance. I ask for new facts and new observations; for now that the cause of the disease is definitely known, we have a fresh incentive for further investigation.

There are many diseases still confused under a common name, just as gonorrhœa and syphilis, typhus and typhoid fever, were confused generations ago, that time will unravel. But as we gain more exact, more precise, and more definite knowledge of any one disease, we shall be the better equipped for appreciating the symptoms and distinguishing the effects produced by others.

Some Observations on Arterial Blood-Pressure in Health and Disease.

BY H. C. MANN, M.D., M.R.C.P. (LOND.).

II.

HEART DISEASE.

Two hundred cases of cardiac disorder admitted into the wards were examined. The majority of these were suffering from symptoms which were indicative of dilatation of the organ; the extent of the disease, valvular and myocardial, was variable, but in most cases it was advanced. For some time after admission records were taken, in many cases four or five times daily, both before and after the exhibition of drugs, and note was taken of any other complications, such as vomiting or coughing, which might tend to produce such changes as occur in normal individuals. From a consideration of the figures recorded we are of opinion that in all cases of "failing heart," the result of either myocardial or valvular trouble, the main diastolic pressure steadily falls, and falls below normal, very rapidly in cases of acute dilatation and where a last fight for life is being made. With regard to systolic pressure, it is very characteristic of all cases of failing heart that individual cardiac beats have a different value, quite apart from any irregularity as regards rhythm and rate. Taking a typical case—after inflating the bag until the pulse had disappeared, it was found that one wave beat in fifteen heart beats, appeared at the wrist at a pressure of 165 mm., the volume of the wave was very small. When the pressure registered 150 mm., three pulse waves, still very small, came through out of a dozen heart beats. At a pressure of 145 mm. six out of twelve beats were felt. At times there was an irregular kick of the left ventricle, occurring apparently as an extra systole which reached as high a figure as 168 mm. Every heart beat was felt at the wrist when the pressure in the bag registered 135 mm., but the waves so appearing were much smaller than those felt at the same time in the opposite wrist (the two pulses were equal in reality), and the full wave was not appreciated by the finger until the pressure in the bag registered 78 mm. As the patient's general condition improved the irregular readings and maximum systolic pressure disappeared; there was a marked rise in diastolic pressure: 78 mm. to 96 mm. The

mean systolic pressure first of all rose somewhat, and then subsequently fell to 130 mm. These changes occurred as a result of rest with medicinal and dietetic treatment. The readings taken in the afternoon were all of them invariably higher than those recorded in the morning, unless there had been some grave change in the patient's condition, thus exhibiting the same tendency to variation which, as has been mentioned above, occur normally in healthy active people. An evening reading taken immediately after the patient had been allowed to get up for the first time showed some rise in the value of the mean systolic pressure, which rise was smaller as improvement in general health was maintained. The diastolic pressure in this case did not show any alteration in value, but not at all infrequently we have observed a fall, and it is our opinion that if a fall in diastolic pressure is observed in such cases, then the patient has been allowed to get up too soon, and more prudent counsels must prevail. In one case which we can recall, but of which we have unfortunately lost the actual figures, the patient had been permitted to get up three times, and on each evening a fall in diastolic pressure had been noted. On the fourth night, she had an attack of acute cardiac dilatation and died.

The actual height of the systolic pressure, as measured by the manometer, depends a good deal upon the presence or absence of left ventricular hypertrophy. Thus in long-standing cases of mitral regurgitation, accompanied by considerable hypertrophy, the reading obtained is considerably higher than the highest readings found in healthy people, but the pressure is only sustained for a very small part of the cardiac systole, and the wave felt is only a small one. In some cases of aortic regurgitation, accompanied by tremendous ventricular hypertrophy, the wave may be felt at the wrist when the pressure measures 190 mm. of mercury, but such pressure is not sustained, it is irregular in value, and consequently of little benefit to the individual, whom it endows with a throbbing headache. Mean diastolic blood-pressure, however, is very low, and we have found it varying from 68 mm. to 100 mm. It is in cases of aortic regurgitation that the greatest extreme is noticed between mean systolic and mean diastolic pressure. In some of our earlier estimations we were inclined to think that, with such a high systolic reading, the aortic incompetence was secondary to renal insufficiency with chronic interstitial nephritis, but this was due to a failure to recognise the low value of the diastolic pressure, and was disproved at the autopsy. A number of our earlier records are valueless for this reason, and are not here recorded (Table X.).

We have noticed that the appearance of the presystolic bruit in cases of mitral stenosis, which is taken to indicate recovery of and increased power of contraction in the left auricular wall, is always accompanied by a rise in the mean diastolic pressure, and until the mitral mid-diastolic bruit of the failing heart gives place to the mitral presystolic bruit, such improvement does not take place (Table V.).

A very rapid fall in the value of the diastolic pressure accompanies pericardial effusion. A fall in the systolic pressure is not at first noticeable, owing to the sharp short "kicking" of the left ventricle giving irregular readings of 160 mm., 170 mm. or 180 mm. (Table VI.).

With the knowledge of the gravity of alcoholic myocardial degeneration, and of the fact that in these cases of "drinker's heart" the interval between the appearance of œdema and the departure to the post-mortem room is only some eight weeks, it would naturally be expected that blood-pressure would be low. In the few cases which we have been able to examine we have found both diastolic and systolic pressures to be of low value, and we have not noticed the same tendency to high, short, irregular systolic "kicking," which is characteristic of failing valvular cases. It would seem that the drinker's heart exhibits little or no tendency to recovery, but a progressive fall of blood-pressure in the arterial system (Table XI.).

The extreme value of venesection in cases of advanced mitral failure, in which condition drugs seem powerless to influence cardiac action, is so generally recognised that a fair number of readings were taken before and after its performance, and, in some cases, during the operation. The amount of blood removed, in every case from the arm, varied, but with those cases in which the quantity of blood removed was eight ounces or under, there was practically no change noticed in either systolic or diastolic pressure. All the patients were adults. When the quantity of blood removed was ten ounces or over (up to twenty-three ounces) the immediate effect of the venesection was a rise in the mean systolic blood-pressure, a marked steadying of the heart's action with a disappearance of irregular maximum systolic readings. At first there was practically no change in the mean diastolic arterial pressure; in about four hours' time a rise was noticed in all cases (Tables VIII. and IX.).

BLOOD PRESSURE READINGS IN HEART DISEASE.

TABLE IV.—Case of Mitral Regurgitation. Woman. Age 23. Admitted for œdema and breathlessness. Rheumatic history. First attack when 16. Organic disease diagnosed two years previously to admission. Readings taken night and morning on ten successive days. Figures refer to millimetres of mercury.

		Diastolic.	Systolic.	Max. Systolic.
1	5.0 p.m. - -	84	110	140 ($\frac{1}{6}$)*
2	9.45 a.m. - -	84	106	150 ($\frac{1}{8}$)
	6.0 p.m. - -	90	120	
3	10.15 a.m. - -	92	120	
	5.30 p.m. - -	96	122	
4	12 noon - -	88	122	140 ($\frac{1}{10}$)
	7.0 p.m. - -	90	122	
5	10.0 a.m. - -	94	124	
	5.0 p.m. - -	96	124	
6	10.15 a.m. - -	96	124	
	5.40 p.m. - -	96	128	
7	9.45 a.m. - -	98	130	
	7.0 p.m. - -	96	126	
8	10.15 a.m. - -	96	126	
	6.0 p.m. - -	98	128	
9	12.30 p.m. - -	98	130	
10	5.15 p.m. - -	98	130	

* One beat in six.

The patient was discharged after three weeks. Heart compensated. Treatment by digitalis. Rest.

TABLE V.—Case of Mitral Stenosis and Regurgitation. Dilatation. Has been liable to heart trouble for seven years. Female. Age 33. Œdema. Bronchitis. Dyspnœa.

		Diastolic.	Systolic.	Max. Systolic.
1	On admission - -	86	110	150 ($\frac{1}{6}$)
2	After a bad night. Some sickness -	84	108	148 ($\frac{1}{8}$)
	Evening reading -	84	110	148 ($\frac{1}{8}$)
3	Third day - -	84	112	148 ($\frac{1}{10}$)
4	Fourth day - -	86	114	148 ($\frac{1}{10}$)
5	Sixth day. Morning	86	120	140 ($\frac{1}{5}$)
	Evening*	90	122	140 ($\frac{1}{5}$)
6	Seventh day. Morning	92	126	
	Evening†	96	126	144 ($\frac{1}{20}$)
7	Ninth day - -	96	130	
8	Tenth day - -	96	128	
	From this time she steadily improved.			
9	Seventeenth day -	94	128	

* Presystolic bruit first heard replacing mid-diastolic bruit occasionally.

† Presystolic bruit constant. Œdema clearing up.

TABLE VI.—To show the effect of pericardial effusion. Female. Age 19. Aortic Regurgitation with Mitral Stenosis.

		Diastolic.	Systolic.	Max. Systolic.
1	Three hours after admission - -	90	126	160 ($\frac{1}{8}$)
2	Second day - -	94	128	154
3	Third day - -	92	128	156
4	Fourth day. Pericardial rub heard	94	?	?
5	Fifth day. Signs of pericardial effusion	84	110	160 ($\frac{1}{10}$)
6	Sixth day. Morning	84	108	158 ($\frac{1}{10}$)
	Evening	82	100	160 ($\frac{1}{10}$)
7	Seventh day. Dying.	No reading.		

TABLE VII.—Fireman, railway. Age 28. Mitral Regurgitation with hypertrophied left ventricle. No œdema. Dyspnœa. Palpitation.

		Diastolic.	Systolic.	Max. Systolic.
1	Shortly after admission - - -	86	130	
2	- - - -	90	134	
3	- - - -	90	132	
4	- - - -	88	138	
5	- - - -	90	140	
6	- - - -	90	138	
7	- - - -	90	140	
8	After getting up first time. Evening reading - -	84	120	150 ($\frac{1}{6}$)
9	Staying in bed. Not so well - - -	88	134	
10	A week later - -	94	134	
	Subsequent improvement.			

TABLE VIII.—Mitral Stenosis. Seven years' standing. Bronchitis. Right-sided dilatation. Venesection (sixteen ounces) at 10 p.m. first night. Male. Age 33.

		Diastolic.	Systolic.	Max. Systolic.
1	On admission—			
	5.0 p.m. -	80	100	160 ($\frac{1}{5}$)
	8.0 p.m. -	80	98	170 ($\frac{1}{12}$)
	11.0 p.m. -	82	120	150 ($\frac{1}{15}$)
2	Second day—			
	8.0 a.m. -	86	120	
	12.30 p.m. -	88	120	
	4.0 p.m. -	88	120	
	10.0 p.m. -	90	124	
3	Third day—			
	10.0 a.m. -	90	124	
	4.30 p.m. -	92	126	
4	Fourth day—			
	10.15 a.m. -	92	126	
	5.30 p.m. -	90	126	
5	Fifth day. Evening	94	124	
6	Sixth day. Evening	96	126	
7	Tenth day. Evening	94	126	
8	Eleventh day—			
	Morning	90	130	
	Evening	96	128	
9	Twelfth day—			
	Evening	96	128	
	Subsequently did well.			

TABLE IX.—To illustrate effect of venesection. Male. Age 26. Mitral Stenosis. Right-sided failure.

		Diastolic.	Systolic.	Max. Systolic.
1	Before venesection -	84	104	150 ($\frac{1}{8}$)
2	After venesection (18 ounces)—			
	Half an hour later -	84	122	
	Two hours later -	84	126	148 ($\frac{1}{12}$)
	Four hours later -	92	128	
	Fifteen hours later -	96	128	
3	Next day - - -	96	126	

TABLE X.—Aortic disease. Hypertrophy and dilatation of heart. Mitral incompetence. Œdema. Bronchitis. Anginal attacks. Daily readings. Male. Age 40.

	Diastolic.	Systolic.	Maximum Systolic.
1.	86	116	170 ($\frac{1}{6}$)
2.	86	116	168 ($\frac{1}{8}$)
3.	88	116	180 ($\frac{1}{8}$)
4.	86	118	174 ($\frac{1}{10}$)
5.	88	120	170 ($\frac{1}{10}$)
6.*	88	110	184 ($\frac{1}{6}$)
7.	88	120	170 ($\frac{1}{8}$)
8.	86	122	160 ($\frac{1}{6}$)
9.	90	120	164 ($\frac{1}{6}$)
10.	88	124	160 ($\frac{1}{6}$)

* Taken after an anginal attack. ? Dilatation of left ventricle. Note the high reading from the irregular "kicking" of the left ventricle.

TABLE XI.—Alcoholic Myocarditis. Cirrhosis of the Liver. Male. Age 43. Death.

	Diastolic.	Systolic.	Max. Systolic.
1. Evening -	80	100	
2. Morning -	78	98	
Evening -	76	96	
3. Morning -	80	60	120 ($\frac{1}{20}$)
Evening -	78	96	
4. Morning -	76	96	

Died.

TABLE XII.—Fatty degeneration of heart. Female. Age 62. Death.

	Diastolic.	Systolic.	Max. Systolic.
1. 6.15 p.m. -	82	90	100 ($\frac{1}{5}$)
9.30 p.m. -	82	100	106 ($\frac{1}{4}$)
2. 10.0 a.m. -	80	100	106 ($\frac{1}{4}$)
7.10 p.m. -	86	100	106 ($\frac{1}{4}$)
3. 6.50 p.m. -	80	100	110 ($\frac{1}{6}$)
4. 10.0 a.m. -	?	92	—

Died in the evening.

Marked changes may be observed in the readings of both systolic and diastolic pressure as the result of administration of certain drugs which are used as cardiac stimulants. The drug which is most commonly used in the medical wards by the house-physicians in cases of sudden cardiac failure, whether due to valvular or myocardial disease, is strychnine. The drug is always given hypodermically, and, excepting *in extremis*, there is found a rise in both diastolic and systolic reading within ten minutes, varying according to the degree of failure and the dose of the drug. Long after the heart has failed, as a result of over-distension, to respond to digitalis, this rise in pressure as a result of strychnine medication is noticed, but the effect is apparently more rapid and lasting if a previous venesection has been performed. The systolic blood-pressure apparently rises before the diastolic, and we are, on this account, inclined to think that the drug has an important action upon the cardiac muscle itself, as well as a central vasoconstrictor action upon the blood-vessels. It is only recently that camphor has been used in Guy's Hospital, subcutaneously, for cardiac stimulation, but, as a result of the doses which we have seen employed, the effect upon blood-pressure is insignificant when compared with strychnine. When there are marked signs of right-sided failure, caffeine produces practically no change in either systolic or diastolic pressure, and in cases of less gravity the effect upon the blood-pressure is invariably less than that of strychnine.

In view of the important and exhaustive research which has been carried on by Dixon with regard to the pharmacological action of the digitalis group, it was with considerable interest that we compared the results obtained from the use of digitalis, strophanthus, and squill. Clinically, there is no doubt that digitalis produces its effects more quickly than either squill or strophanthus, slowing the heart's action and increasing the force of the systole. The effect of the administration of digitalis is shown in a marked rise, first of all of the systolic mean pressure, and, later, a rise in the diastolic pressure, though the rise in the latter pressure is frequently delayed four, six, or even ten days, and until it occurs *no* diuretic effect is noticed. The rise in mean systolic pressure is frequently found to occur within three hours, and is accompanied by a disappearance of the irregular excitable contractions of the heart, which, as it has been mentioned above, are frequently present in cases of "failing heart," and produce maximum sytolic readings. Hypodermic injection produces in many cases a marked effect within an hour, though in some cases it is necessary to relieve the distended right heart by means of a venesection. In simple cases of mitral regurgitation a rise of systolic blood-pressure, equivalent to twenty millimetres of mercury, may be noticed within six hours as the result of a single dose of the tincture of digitalis (20 minims) by the mouth. The patient had, in the meantime, been resting in bed.

Strophanthus, administered in pharmacopœal doses, produces very little rise, if any, in diastolic pressure, and a rise in systolic pressure which is transitory and smaller than that produced by digitalis.

Squill, when administered in the form of the official tincture, produces apparently only a slight rise in blood-pressure—and does not seem to produce any alteration of importance in the cardiac rate. This drug is considered by Dixon to be by far the most potent, in pharmacological action, of the three, when tested bio-chemically.

Nitro-glycerin, when administered either by the mouth or hypodermically, produces a marked

fall in both systolic and diastolic blood-pressure, but if it is desired that the effect should remain for any length of time, increasing doses are necessary. In one case with which we came in contact the patient, a man of sixty-nine years, was in the habit of taking thirty or more tabloids of nitro-glycerin (B.P.) a day. He had found that, as a result of this medication, attacks of cardiac pain were warded off. He was suffering from arterio-sclerosis with aortic incompetence, and the attacks were apparently due to over-distension of the left ventricle, that is to say, secondary cardiac angina (Douglas Powell). On admission the blood-pressure was found to correspond to 170 mm. systolic and 120 mm. diastolic. It was thought advisable that the administration of the nitrite should be reduced in amount, and reserved for attacks of cardiac pain. The arterial blood-pressure was estimated every two hours for the first twelve hours, and during this time only four tabloids had been taken. He was by this time anxious and restless, and complaining that if his craving for the drug were not satisfied he would certainly die. The systolic blood-pressure had by this time risen to 190 mm. In eighteen hours the reading was 198 mm.—he had taken one more tabloid, and had obtained some sleep. In another two hours' time it was 202 mm., and he was very anxious.

Twenty-three hours after admission the systolic blood-pressure was found to be 204 mm., and ten minutes later he died suddenly. At the autopsy acute dilatation of the left heart was found. There was atheromatous disease of the aorta and valves; hypertrophy of left ventricle; the coronary arteries were thickened, but their lumen apparently not obstructed. The heart weighed twenty-four ounces. The kidneys showed early interstitial degeneration. We conclude that, as a result of heroic doses of nitro-glycerin, the patient was able to exist with an arterial blood-pressure low enough to avoid acute dilatation, and high enough to permit of the performance of renal excretion in a degenerating organ. (Table XV.) In other cases of angina pectoris (primary cardiac angina), as a result of nitrite administration, the blood-pressure has fallen below normal, though this is not invariably the case. (Table XVI.) When attacks of palpitation occur, there seems to be a marked fall in diastolic pressure, and an appearance of maximum irregular systolic readings, with slight rise in the systolic pressure sometimes. As a result of the administration of bromides, the irregular "kicking" disappears, and there is a slow rise in diastolic pressure with a steadying of the heart's action. Iodide of potassium possesses apparently the same action in a less degree, and this may account for the disappearance of the throbbing headache of aortic regurgitation which results from the exhibition of that drug.

As a result of the administration of morphia in cases of delirium complicating aortic disease, the slowing of the pulse is accompanied by a rise in diastolic blood-pressure and a disappearance of irregular systolic readings. Such an effect is only what would be expected from our knowledge of the use of morphia in heart trouble, and we have found similar improvement after the use of hyoscine hydrobromide for aortic delirium. (Table XVII.)

TABLE XIII.—The effect of strychnine injections upon blood-pressure in a case of Acute Dilatation. The bag was kept on the arm and the reading taken every two minutes. (Inject. Strych: Hyp. $\mathfrak{m}$. viij.)

		Diastolic.	Systolic.	Max. Systolic.
1	Before injection	?	80	
2	Two mins. afterwards	?	80	
3	Four " "	?	88	140 once
4	Six " "	? 76	90	only
5	Eight " "	?	94	
6	Ten " "	76	100	152 ($\frac{1}{8}$)
7	Twelve " "	78	110	
8	Fifteen " "	80	120	148 ($\frac{1}{8}$)
9	Twenty " "	88	128	146 ($\frac{1}{10}$)
10	One hour "	90	120	
11	Next day	94	126	

We have taken about twenty readings, which show somewhat similar results. This case was one in which the patient seemed absolutely *in extremis*. It was impossible to estimate diastolic pressure. We were of the opinion that she was dying. Did strychnine save her life?

Female. Age 32. Aortic disease. Mitral regurgitation.

TABLE XIV.—The effect of digitalis administered by the mouth. Mitral stenosis and regurgitation. Adult. Age about 30. Dose: Tinct. Digitalis $\mathfrak{z}$ xv. 4 tis. horis. Œdema. Bronchitis. Daily readings.

	Diastolic.	Systolic.	Max. Systolic.	Pulse rate.
1. (On admission)	88	118	130 ($\frac{1}{8}$)	130
2. - -	90	120	—	120
3. - -	86	118	140 ($\frac{1}{10}$)	122
4. - -	88	124	—	116
5. - -	88	126	—	112
6. - -	94	128	150 once	100
7. - -	96*	128	—	104
8. - -	100†	128	—	96
9. - -	98	130	—	92
10. - -	100‡	128	—	92
11. Four months later came up to the Surgery	110	134	-	—

* Presystolic bruit first heard.
† Diuresis began.
‡ Œdema obviously clearing up.

TABLE XV.—The effect of nitro-glycerin, in heroic doses, upon the blood-pressure of a man, aged 69, liable to angina pectoris. Dose, self administration: 30 tabloids B.P. per diem.

		Diastolic.	Systolic.
1.	On admission. 12.30 p.m.	120	170
2.	- - 2.15 p.m.	134	174
3.	- - 4.0 p.m.	134	182
4.	- - 6.0 p.m.	140	182
5.	- - 8.0 p.m.	146	184
6.	- - 10.0 p.m.	142	182
7.	- - Midnight	150	190
8.	- - 6 0 a.m.	160	198
9.	- - 8.0 a.m.	160 ?	202
10.	- - 10.0 a.m.	?	204
11.	- - 11.30 a.m.	He died.	

Up to midnight (7) only four tabloids had been taken. Up to 6 a.m. (8) one more tabloid allowed.

TABLE XVI.—Female. Age 32. Aortic Regurgitation. Angina Pectoris. Amyl nitrite inhalations.

	Diastolic.	Systolic.	Max. Systolic.
1 Usual reading - -	92	120	
2 After an attack of angina - - - Amyl nitrite administered.	82	130	150 ($\frac{1}{10}$)
3 Another attack - Same treatment.	90	140	146 ($\frac{1}{8}$)
4 Another attack - Same treatment.	84	138	
5 Another attack - Same treatment.	78	136	148 ($\frac{1}{8}$)

The above readings were taken about half an hour after each anginal attack. For obvious reasons it has not been possible to obtain a record during the attack.

TABLE XVII.—Male. Age 52. Atheroma. Aortic Regurgitation and Stenosis. *Delirium.* Readings to show the effect of morphia and hyoscine administration.

	Diastolic.	Systolic.	Max. Systolic.	Pulse per min.	Heart Beats per min.
1 Usual reading -	86	154	170 ($\frac{1}{10}$)	90	94
2 Cardiac delirium appeared - -	82	164	184 ($\frac{1}{16}$)	116	128
3 Morphia injection* half an hour after	90	150	160 ($\frac{1}{12}$)	97	98
4 A week later -	86	148	—	80	82
5 Delirium - -	82	166	180 ($\frac{1}{10}$)	120	124
6 Half an hour after an injection of hyoscine† - -	90	130	—	98	98

* Morphia injection, gr. $\frac{1}{4}$ + gr. $\frac{1}{8}$.
† Hyoscine, gr. $\frac{1}{200}$.

The patient died about three weeks later with symptoms of acute dilatation of the heart.

(To be continued.)

Miller Fund.

	£	s.	d.
"G. H. K. M."	1	1	0

In Lighter Vein.

BRIDGE.

When the tired dresser, who
Toils the take-in week through,
Goes upstairs, wishing to
Leave, but unable;
His lot is not so hard,
For, tho' escape be barred,
Packs and a scoring card
Lie on the table.

Colleagues with nought to dress
Drag up the tired H.-S.,
And for an hour or less
None need the fun dread;
For rubbers won or lost,
That is, unless you've tossed
Double or quits, will cost
Fivepence a hundred.

Tempered tho' be the fun
When the clerk, just begun,
Holding but ace and one,
Throws you the lesser.
Still, as his time proceeds
He'll deal in doughtier deeds
And give you Dalton's leads
Pat, as a dresser.

But when the warning bell
Tolls once its dreaded knell,
Though ye would fain rebel,
You can't reprieve it.
And be your just dealt hand
Awful or simply grand,
Still, you will understand
Now you must 'leave it'!

S. S.

Boro' Orthography.

A LETTER RECEIVED BY THE EXTERNS.

GENTLMEN, — Would You kindly Rendar Your Services tow-ards me Hav-ing being In Great Pain. I believe a Mescary Coming On In haste is the Result.—I Remain, Yours Respectfully, Mrs. X.

Guy's Hospital Debating Society.

OFFICIAL REPORT.

The eighty-third meeting of the Society was held on January 18th. Dr. Spriggs in the chair.

The Chairman, after signing the minutes of the previous meeting, called on Mr. Neville Cox to propose, "That this House believes in the principle of One Man, One Vote."

Mr. F. Cook opposed, and Messrs. Killpack and Bennett, respectively, seconded the proposition and opposition.

The Chairman then threw the subject open to discussion and the following members spoke: Drs. Spriggs and Mann, Messrs Brookhouse, Reynolds, McEvedy, Thompson, Stout, and Cooper.

The opposer and proposer then replied, and on the motion being put to the House it was lost by one vote

A hearty vote of thanks concluded the business.

Reviews, etc.

The price of books submitted for review should in every case be stated.

Ophthalmia Neonatorum, with especial reference to its Causation and Prevention (the Middlemore Prize Essay, 1907). By Sydney Stevenson, Ophthalmic Surgeon to Queen Charlotte's Hospital, London, etc. (London: Geo. Pulman & Sons.) 12s. 6d. net.

This is a very complete monograph on the subject of Ophthalmia Neonatorum, and besides treating of the disease from a medical point of view, the author also gives some extremely interesting historical facts, which illustrate very forcibly the development of medical opinion with regard to bacterial disease. What, however, will interest our readers most, will be the author's conclusions with regard to the prophylaxis and treatment of Ophthalmia Neonatorum. Crede's method of treating the eyes of all newly-born children with a 2 per cent. solution of silver nitrate is, in a modified form, strenuously advocated by Mr. Stevenson. He quotes statistics which show that where Crede's method has been employed, the percentage of cases affected with ophthalmia has been reduced to less than one in a series of about 75,000 patients; whereas, in another collection of 4,800 cases taken from the Metropolitan area, the percentage of ophthalmia was found to be 3·6, no special treatment having been employed in these latter cases.

The ætiology of the disease is investigated very thoroughly, and the author clearly demonstrates that the Gonococcus is by no means the only organism responsible for this form of purulent ophthalmia. Pneumococci and Bacillus Coli Communis are responsible for a large percentage of the cases. This clearly proves the impossibility of entirely eradicating the disease by Crede's method only.

With regard to treatment, the author seems to be very undecided as regards the respective merits of protargol, argyrol, and silver nitrate; after having quoted an expression of opinion in favour of protargol, written by himself in 1900, he tells us that in 1907 he remains of the same opinion, notwithstanding the fact that for the last three years he has used argyrol "almost to the exclusion of protargol"; and in the succeeding paragraph he tells us that "If a decided impression be not made upon the disease after a few days' (3 or 4) treatment, I never hesitate to resort to silver nitrate," and further, "A corneal ulcer not healing under argyrol or protargol, furnishes me with another very definite indication for silver nitrate." This shows that the more recent remedies have not, even in his opinion, proved sufficiently trustworthy to entirely supplant the older one.

The book displays great industry on the part of the author, but, as is so common in books of this description, the reader is wearied by quotations from all sources of Continental and American writers, irrespective of whether the views thus quoted have been promulgated by responsible authorities or not, and which in many cases dogmatically state facts which are diametrically opposed. In consequence, from a literary point of view, the book is almost unreadable, but as a book of reference it remains an example of completeness. It is especially valuable to the ophthalmic surgeon rather than to the general practitioner.

The book is well printed, is on good paper, and has a very complete and satisfactory index. We congratulate the author most heartily upon his work.

Art of Prescribing. By C. R. Marshall, M.D. (J. & A. Churchill.) Price 5s. net.

This volume, written more or less from the point of view of the practitioner, deals with the art of prescribing rather than the art of dispensing; nevertheless an excellent chapter on dispensing is included. The chapter on Incompatibility will be found useful.

Maternity Nurses' Guide. By Gertrude C. Marks. (Bailliére, Tindall & Cox.) Price 1s. 6d. net.

This hand-book is what the authoress terms a "Daily Guide," being but the headings of facts necessary for a maternity nurse to be acquainted with. It is a pocket volume, but even as such is extremly sketchy, and we doubt whether there is a call for such a "Guide." The average maternity nurse will find little therein that is not the A.B.C. of her curriculum.

Pocket Book for Physicians and Pharmacists. We have received a compact, useful little memorandum book from Messrs. Evans, Gadd & Co., Ltd., Fore Street, E.C. The above-named firm will be pleased to supply this note-book to any of our readers who care to apply.

Sport.

Rugby Football.

GUY'S v. LENNOX.

This match was played at Wimbledon on Saturday, January 18th, and was our first game after the Xmas vacation, our matches against Catford and U.C.S. Old Boys having been scratched owing to frost.

Guy's won the toss, and immediately pressed, but were unable to score, owing to faulty passing. Lennox were playing well, and almost scored. Guy's again attacked, through splendid kicking by Stringer. Saner broke away well from the scrum, and passing to Pritchard the latter scored a good try. Lee converted. After some play in mid-field, half-time was called, Guy's leading by 5—0.

The forwards, who throughout had heeled well, again gave the backs many chances, but faulty passing prevented any score, until the ball was at length properly handled, and Stringer scored from half-way. The kick failed. On the re-start, Lennox pressed, and their forwards were almost in, but Hind brought off a magnificent tackle. The forwards now carried the ball back, and, after a series of good bursts, Archer scored. Hind failed with the kick. Lennox again were pressing, but time was called, with the score 11—0 in favour of Guy's.

Remarks.—Patey, though slow, did very well; the three-quarters' defence was good, but the attack was weak owing to inaccurate passing. The halves were excellent, Saner especially playing well. The forwards exhibited very good form after their long rest, Archer Crook, and Hoby shining in the loose.

TEAM:—P. E. Patey (back); L. B. Stringer, P. J. Monaghan, H. Lee, W. E. Digby (three-quarters); G. B. Pritchard, J. G. Saner (halves); H. R. Mullins, H. Archer, W. E. Williams, G. R. Hind, H. H. Crook, H. Hoby, A. Moberly, C. G. Sprague (forwards).

CUP TIE DRAW.—1ST XV.

Guy's v. Westminster, Bart.'s v. Thomas's, Mary's v. University, Middlesex v. London, King's v. Charing Cross.

If successful in their match, Guy's will meet the winner of Thomas's and Bart.'s.

Association Football.

GUY'S 2ND XI. v. SIDCUP "A."

Played at Honor Oak Park, on Saturday, January 18th. The visiting team began the game with two men short for the first ten minutes, during which time we scored three goals. Afterwards, with a full side, they gave us a much better game, but we managed to hold the upper hand all through, and finished up with five goals to their one. Our first goal was scored by Hinde, from a centre by Hole. Wain was well fed, and secured two goals as a result of combined runs up by our forwards. Many of these, however, were wasted. Jones was responsible for the other two goals. Our halves did not find themselve overworked. The visitors' goal was due to slackness on the part of our backs, their centre forward running through and scoring with a lucky cross shot. On other occasions Rook saved well.

TEAM:—C. H. Rook (goal); C. A. Wood, W. Johnson (backs); C. E. Reckitt, P. V. Pedrick, H. L. Gibbons (half-backs); K. H. Hole, Wain, E. B. Hinde, T. L. Jones, C. W. Greene (forwards).

Appointments.

Civil.

STEWART, W. G., M.B., B.S. Lond., M.R.C.S., L.R.C.P., has been appointed Assistant Honorary Medical Officer to the General Infirmary, Hertford.

Papers by Guy's Men.

Some Physiological Aspects of Gastro-enterostomy (Illustrated). By Hector Charles Cameron, M.A., M.B., B.C. Camb.—*British Medical Journal*, 18th January, 1908.

Chronic Appendicitis in Women. By W. Sampson Handley, M.S. Lond., F.R.C.S. Eng.—*West London Medical Journal* for January, 1908.

Lectures on the Passage of Food through the Human Alimentary Canal (Illustrated). By Arthur F. Hertz, M.D. Oxon., M.R.C.P. Lond.—*British Medical Journal*, 18th January, 1908.

Remarks on the Results of the Operative Treatment of Chronic Constipation. By W. Arbuthnot Lane, M.S. Lond., F.R.C.S. Eng.—*Ibid.*

BOOKS, &c., RECEIVED.—Fagge's Pocket Anatomy; Rule's The Pyonex; Eccles' Hernia, third edition; Richmond's Disease: Its Cause and Prevention; West London Medical Journal; Archives Générales de Médicine, Nachrichten von der Koniglichen Gesellschaft der Wissenschaften zu Gottingen, Dec., 1907; Schmidt's Jahrbücher der gesammten Medicin; Medicinsk Revue (Norway); Pharmaceutical Journal.

Births.

BENTLEY.—On December 27th, 1907, at Haworth, Mitcham, the wife of Harold Bentley, B.A. Camb., M.R.C.S., L.R.C.P., of a daughter.

SCOTT.—On December 8th, at the Mall, Wanstead, Essex, the wife of Philip Scott, of a daughter.

STEWART.—On January 15th, at Ware, Herts, the wife of W. G. Stewart, M.B., B.S. Lond., of a daughter.

Death.

STEVENSON.—On January 17th, at Sandhurst Lodge, Streatham, S.W., Lady Stevenson, wife of Sir Thomas Stevenson, M.D., aged 68.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXII., No. 512.] FEBRUARY 8, 1908. [SIXPENCE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

February.

Sat. 8. 1st XV. v. Blackheath at Blackheath.
2nd XV. v. Lennox "A" (Home).
1st XI. v. Old Citizens (Home).
2nd XI. v. Old Askeans (Away).

Mon. 10. Special Clinical Lecture by Mr. Steward at 1.15.

Wed. 12. 1st XI. v. Emerité (Home).

Thur. 13. Mr. Lane's and Sir Cooper Perry's Take-in commences. (Messrs. Walker and Ticehurst.)

Fri. 14. Meeting of Dental Society at 4.30 p.m.

Sat. 15. 1st XV. v. Plymouth (Away).
2nd XV. v. London Scots "A" (Home).
1st XI. v. London Devonians (Away).
2nd XI. v. Reigate Priory "A" (Home).
"Ladies' Night" Debating Society at 8 p.m., College.

Mon. 17. Special Clinical Lecture by Mr. Iredell.

Wed. 19. Physical Society Discussion, "Constipation." President, N. Flower.

Thur. 20. Mr. Dunn's and Dr. Shaw's Take-in commences. (Messrs. Smalley and Goodhart.)

Passim.

IN view of the interesting account of the operation on Hoo Loo performed by Sir Astley Cooper in 1831, which we have been enabled to publish owing to the courtesy of Mr. Henry Williams, who has so kindly furnished us with a *Standard* of that date, some historical notes on the foundation of our Museum may be found of interest. It undoubtedly dates from the last century, for the catalogue of 1804 shows many entries. Contributions were few and far between, since post-mortem examinations were held only on special application being made by the Medical Officer to the Steward of the Hospital. In 1814 a new system was founded, and a special staff—what would correspond to our present-day demonstrators of morbid anatomy—was appointed. The first person to hold this appointment was Mr. Dodd, and to him we owe the nucleus of our "new" museum. In 1825 Dr. Hodgkin was appointed Curator, and his catalogue, published in 1829, includes 3,000 specimens. Sir Astley Cooper contributed many surgical preparations, and then followed the great wax modeller, Towne, whose reproductions have handed his name down to posterity as the greatest artist, in his special branch, of all times.

ANOTHER point of interest is the status of dressers at that period. We quote from Sir Samuel Wilks' and J. T. Bettany's Biographical History of Guy's Hospital:—

> "The dressers carried a tin box containing plaisters, instruments and bandages, whilst the other pupils crowded round, and at that time took off their hats. . . . The box which the dresser carried was not unlike a knife-box, and is the subject of a skit which appeared in the *Lancet*, when that journal was not animated with the best feelings towards the hospital, and was proposing to start a new College."

THE unpleasantness which existed between the hospital and the *Lancet* was due to the Wakley—B. Cooper libel suit in 1828. The *Lancet* having published a libellous account

of an operation performed by Mr. Benjamin Cooper — Sir Astley's nephew — the surgeon successfully obtained the verdict in a case which excited much public interest. A model made of a man, showing sections, used as evidence in the case, is in the museum at the present time.

The skit published by the *Lancet* is worthy of reproduction :—

"With every weapon stored for waging war
Against foul ulcers scented from afar;
Well armed with instruments of rusted steel,
With plaisters, bandages and linseed meal,
The well-known box to every dresser wed
With heedless haste is thrown upon the bed,
Lighting perchance on some poor devil's toe;
The echoing ward rings with the shrieks of woe.
With feeling heart the dresser turns him round
And slowly sets his box upon the ground."

Oh! shade of Wakley, visit us now!

We are always pleased to chronicle the success of any old Guy's man, and we congratulate Capt. Rowell, of East Rudham, Norfolk, on the victory gained by D Company, 3rd Volunteer Battalion, Norfolk Regiment, of which company Capt. Rowell is Commanding Officer. This company was successful in carrying off the handsome and much-coveted cup presented by King Edward for efficiency, and Capt. Rowell was the recipient of much congratulation on the occasion of the annual prize distribution at Fakenham, at which the Lord Lieutenant of Norfolk, Colonel the Viscount Coke, K.C.V.O., C.M.G., presided. During the proceedings a telegram was received from His Majesty warmly congratulating the Fakenham Company on its success.

On another page will be found a letter from Mr. F. Barker outlining what seems to us an excellent scheme, whereby not only could ever-welcome funds be raised for the hospital, but also interest in our historic institution be increased generally. Guy's, with its traditional and interesting environment, lends itself uncommonly well to a scheme of this sort. Mr. Barker suggests that a series of lantern slides be prepared, not only of the hospital itself, but also of the parts of the Boro' rendered familiar the world over by Dickens. These slides, together with an appropriate description, are to be hired out for the use of old Guy's men and others for the purpose of illustrated lectures. The scheme is in every way practicable, and we would be pleased to receive from our readers any suggestions conducive to its advancement.

We congratulate Dr. Wade on his clear well-written report on the effect of sulphur dioxide as a destructive agent for the much-harassed rat, and as a general disinfectant for ships' cargoes. Dr. Wade, in conjunction with Dr. Haldane, in 1903–04 carried out a series of experiments on sulphur dioxide as a fumigating agent, at the instigation of the Medical Officer of the Local Government Board; the present report embodies the result of work which Dr. Wade has recently done, more particularly with a view to studying the effect of the gas on the cargo itself. At a time when such active prophylactic measures are being taken against the introduction of plague, this report will doubtlessly be of great value.

A correspondent writes to us with what we have no doubt is a well-founded grievance. He refers to the state in which the various journals and papers in the smoking-room are kept. Of late we have heard many complaints of this nature, and ourselves have encountered no small difficulty in unearthing from a heap of crumpled grease-stained journals a single number which could with any degree of comfort be read. The *Bystander* seems the journal which most suffers; two days after its arrival we have seen parts of it on the tables, on the floor, scattered all over the room: even the staid and formal A.B.C. does not seem to be exempt. We hope this state of affairs will soon be remedied, and in passing would like to make a suggestion, to wit, that the *Telegraph* and *Sportsman* should be filed and kept in the library, an honour which at present the *Times* alone is elevated to.

On the 15th inst. the Debating Society holds its annual "Ladies' Night." The subject to be discussed is "That in the opinion of this

House politeness pays," and the chair will be taken by Dr. Savage at eight o'clock punctually. We trust that members of the Society will attend in force and that the fair sex will have no excuse for not being present owing to lack of persuasion. This annual fixture is quite one of the features of the Society's meetings, and as we are promised a lively debate, we have no doubt that the attendance will be a record one.

The First XV. continues to keep untarnished its clean slate. The game against Oxford was productive of much good play, and the result—nine points to eight in our favour—shows what a closely-contested match it was. Westminster Hospital scratched in our match in the First Round of the Cup-Tie, so that now we meet St. Bartholomew's, who on Tuesday last defeated St. Thomas's by 21 points to 3. The Bart.'s team is stronger this year than last, and have been playing well. The winner of the Bart.'s–Guy's match will meet, most probably, London in the final. London have yet to play in the First Round, but the issue is in no doubt whatever. The Final is fixed for March 4th.

The First XI. have already won a Cup; we refer to the London University Association Cup, which is presented for competition amongst the various affiliated colleges of the University. Guy's met East London College in the Final Tie and won rather easily by 5 goals to 1. We trust that this is a good augury, and that the Inter-hospital trophy will again grace the Smoke Room.

A few remarks to our readers of the Dental Department. The Gazette not only serves as the organ of the Clubs' Union to report the meetings, etc., of the constituent clubs, but also is a channel by which old Guy's men, medical and dental, can give voice to ideas connected with their profession, and also to a great extent keep in touch with their Alma Mater when they leave to commence practice. The dental man, it is true, spends much less time as a student in hospital, so naturally his interests in hospital affairs are not so wide as the medico's. Nevertheless, the Dental School is now a big part of the whole, ranking, as it does, with the Royal Dental Hospital as the premier school in England, so that it must have great interests of its own. We propose, if the support be forthcoming, to devote a certain space in each number to dental matters, and will welcome any original articles and ideas from dental men; dental clinical lectures will be published at regular intervals, and points of interest in dental technique, etc., will receive adequate attention. Our dental correspondent, Mr. Doubleday, will be pleased at any time to receive suggestions.

The Annual Dinner of the Dental Society will be held on Saturday, February the 22nd, at the Trocadero Restaurant. The President, Mr. Pearce, is to take the chair, and an excellent musical programme has been arranged. This dinner affords an admirable opportunity for an annual reunion of old Guy's Dental men, and it is hoped that they, and any others interested, will turn up in large numbers, and make the dinner a great success. Tickets, price 6s. 6d., may be obtained from the Hon. Sec., Mr. R. M. King, at the hospital.

Change of Address.

Mr. Dudley Kennard, F.R.C.S., from the French Hospital, 172, Shaftesbury Avenue, W.C., to 6, Woburn Square, W.C.

Mr. Chas. Heygate Knowles, L.D.S. Eng., from 13, Lyndhurst Road, Hampstead, to 47, Rosslyn Hill, Hampstead, N.W.

Mr. T. B. Layton, M.B., M.S. Lond., from Guy's Hospital, to Faircote House, Pocklington, York.

Dr. A. M. Moore, from 110, Burnt Ash Road, Lee, S.E., to 359, High Street, Lewisham, S.E.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

The Residents' Theatricals Souvenir.

THE edition is nearing completion, and is now in the binders' hands. Much encouragement has been received by the number of applications which are coming in from outside the hospital. Probably many are delaying sending in their forms, objecting to the "pig-in-the-poke" method which is rendered necessary in publishing any book by subscription. For the benefit of these the surplus over the first edition will be obtainable in the hospital, but let them be advised that this surplus will not be a large one, as the edition is already almost fully subscribed. Forms may be had from Copsey, and may be left with him.

We beg to acknowledge receipt of application forms from the following:—Mrs. Frederick Taylor; Misses Harris and Newton; Drs. Galabin, Hale White, Sir Alfred Fripp; Messrs. Allen, A. Alcock, F. Alcock, Cooper, Eastes, Davies, Ensor, Evans, Fagge, Fuller, Gunton, Hammond, Henderson, Hinde, W. Johnson, Layton, Leeming, Mullins, T. Poole, Rippmann, Spon, Sutton, Shufflebotham, Scott-Foster, Jr., Shahin, H. Visick, and Wheeler.

Appointments.

Civil.

GLOVER, J. ALISON, M.A., M.D. Cantab., D.P.H., has been appointed Deputy Medical Officer of Health to the Islington Borough Council.

TELLING, W. H. MAXWELL, M.D., B.S. Lond., M.R.C.P. Lond., has been appointed Honorary Surgeon to the Cockridge Convalescent Hospital, Leeds.

WOOD, WALTER R., L.R.C.P. Lond., M.R.C.S., L.D.S. Eng., has been appointed Dental Surgeon to the Sussex County Hospital.

Naval.

Fleet-Surgeon C. M. BEADNELL, R.N., has been appointed to the *King Alfred*, and Fleet-Surgeon J. D. HUGHES, R.N., to the *Donegal*.

Surgeon GUY L. BUCKERIDGE has been posted to Portland Hospital.

Dr. ALBERT MARTIN, has been appointed Consul of Chile at Wellington, N.Z.

Pupils' Physical Society.

A PATHOLOGICAL MEETING was held on Saturday, February 1st, in the Wills Library, Mr. Rippmann in the chair.

The following specimens were shown:—

Tuberculous ulceration of intestine with perforation, and An ectopic gestation. E. P. H. Joynt.

An interstitial gestation. Jan Mohamed.

A brain with secondary growths of endothelioma. Neville Cox.

Liver with actinomycotic patch. C. A. Wood.

A breast deeply ulcerated with carcinoma. Also a kidney, hydronephrotic from calculi (removed at operation). P. P. Laidlaw.

Carcinoma of body of uterus. Carcinoma of cervix of uterus. A parovarian cyst. An ovary and tube showing accessory ostium. R. Davies-Colley.

A kidney from a child of 6 months old with a large suprarenal. Testicle with carcinoma. C. H. Rippmann.

Discussion followed, in which Messrs. Goodhart, Laidlaw, Davies-Colley, Welchman, Joynt, Wood, Greenwood, Jan Mohamed, Cooper, and the Secretary took part.

The meeting adjoured at 9.30 for coffee.

The next meeting will be held in the College on the 19th February, when a discussion will be held on "Constipation." It is hoped that all members will attend and join in this discussion.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

NOTICE.

C. R. N., KENSINGTON.—This sputum consists of mucus and milk-clot, and very little muco-pus is present. There appears to be admixture of much material regurgitated from the stomach. Moderate numbers of pneumococci are present, in association with abundant yeasts and numerous filamentous rods. Neither tubercle bacilli nor influenza bacilli are found. The yeasts and filamentous rods are probably contained in the regurgitated material. The pneumococci are not sufficiently numerous to be of definite significance.

PATHOLOGIST.

Miller Fund.

	£	s.	d.
Half Profits on Raffle of Nigger Pictures ...	1	11	6

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

An Interesting Suggestion.

SIR,—Every little helps, and a chance conversation induces me to suggest the following as a means whereby money may be raised for, and interest aroused in, our Hospital. My suggestion is that a series of magic lantern slides be made of Guy's Hospital, and a popular history of it written; and that these be kept ready for loaning to present and past Guy's men for the purposes of lectures. This method has already been found remunerative in the case of a country hospital with far less interesting a history than ours, and I feel sure that many members of Guy's would be only too willing to arrange for, and give, lectures, if aided by lantern slides and interesting details of the Hospital's history.

The photos of the present-day buildings that have been produced by the energy of the Nurses' Photographic Society and others would make admirable lantern slides, and copies of old prints could be made without much difficulty. A few views of the Guy's district would also be interesting—not omitting the old "George Inn"—and a pictorial insight into some of the one-roomed tenements visited by the Externs could hardly fail to increase any collection after the lecture. The accompanying word-matter should be designed to suit the tastes of varying lecturers and audiences, but a point should be made of the great advances in every department, and a judicial combination of the humorous and pathetic nearly always adds to the financial result.

The Hospital at present possesses several first-class amateur photographers, and perhaps the authorities might see their way to allow slides of the fine oil paintings in the Court Room to be made. A short biographical account of these old Guy's heroes would add to the interest of the lecture.

This, Sir, is only an outline, but perhaps, through your columns, it might be given practical shape, and produce a tangible result.—Yours truly,

February 1st. F. A. BARKER.

A Much Needed Reform.

DEAR SIR,—May I, through the medium of your columns, venture to draw the attention of those in authority to the present condition of the weekly papers taken in the Club Smoking Room?

For the past two months or more, it has been almost impossible—except on the actual day the papers come in—to obtain a copy which is not tattered or mutilated in some way; sometimes they are quite unreadable owing to the number of missing pages—often they are not forthcoming at all.

It would seem that, either they are never placed in their covers, or else they are not properly secured in these, and hence fall out on the slightest provocation.

In addition to this, although *Country Life* and *The Bystander* appear now to be regularly taken in, no steps seem to have been taken to procure new covers for them, or in any way to utilise the old ones.

Sir, I think that the majority of those members who utilise the Smoking Room will fully endorse what I have pointed out, and will agree that prompt measures ought to be adopted to rectify this state of affairs, which reflects very little credit on those who have the management of them.

Thanking you in anticipation.—I remain, yours, etc.,

The College, LECTOR.
February 4th.

Guy's Physiological Society.

A MEETING was held on February 3rd, at which Mr. Turner presided. A paper was read by Mr. H. F. Stephens on "Woman's Place in Nature."

It seems to be a biological fact that everywhere in Nature, the males are more active and katabolic, the females more passive and anabolic. Physiological researches have confirmed this metabolic characteristic of the sexes, and have shown that the so-called "secondary sexual characters" are the direct outcome of this primary difference. Further, all evidence goes to show that this metabolic difference is dependent upon constitutional conditions, and may be directly attributed to the possession of a testis by the male, and an ovary by the female. This metabolic difference has been the chief factor in the progressive evolution of every type, for it is through the katabolic activities of the males that variational tendencies dependent on conditions of environment have been introduced for the greatest advantage; while it is the anabolic stability of the females that has produced their greater capacity for perpetuating all such variations for the good of the species. The higher in the scale of evolution a species has reached, the greater is the anabolic tendency of the female; because the higher the evolution, the longer the infancy of the offspring, and the greater the necessity for its mother's care and nutrition. Man being the most favoured of all species, the ideal mothers should be the mothers of the human race. What, then, is the meaning of the physical deterioration, falling birth-rate, and rising mortality amongst the new born? The tendency of the civilisation of to-day is to render women less anabolic. This tendency is seen in the modern requirements of education, the economic necessity for female labour, and the unwholesome and unnatural conditions under which women work. A nation's first duty is to secure the welfare of its posterity. To do so, it must begin at the beginning and secure the welfare of its daughters, its wives, and its mothers.

Hoo Loo:
The Famous Chinee, Operated on by Mr. Key in 1831.

WE have received from a correspondent a *Standard* of April 11th, 1831, in which is graphically detailed the operation performed by Mr. Key on Hoo Loo, and which we reproduce below.

All old Guy's men, and most of us at present here, must remember the old oil painting, which was so conspicuous in the old Museum, and which is at present on the walls of the Curator's room, depicting Hoo Loo with his enormous scrotal tumour. Many must have been unacquainted with its history, and we are indebted to our correspondent for the interesting number of the *Standard* which he has forwarded us. Appended are some facts culled from the Museum Catalogue. In the *Lancet*, 1830–31, vol. ii., p. 86, is a further account which proves very interesting reading. The *Despatch* of a week later also gave an account, and what wide-spread interest this operation caused may be seen by the anxiety of many to obtain some memento of the occasion.

One is struck by the names of those present—what a distinguished coterie! Sir Astley Cooper, Drs. Bright, Addison and Hodgkin, Mr. B. Cooper, Mr. Key, etc., a veritable congeries of giants!

The horrors of the pre-anæsthetic days are well brought home to one, the fortitude and inurement of patients in those days sets one marvelling, still another incident which attracts attention is the furnishing of eight ounces of blood, for transfusion into the patient during the operation, by one of the students present.

Verily "Autre temps, autre mœurs."

From *The Standard* of Monday, April 11th, 1831.

OPERATION UPON HOO LOO, THE CHINESE, FOR A TUMOUR IN GUY'S HOSPITAL.

(BY AN EYE-WITNESS.)

In consequence of Saturday last being the day appointed for removing the extraordinary abdominal tumour from the Chinese, Hoo Loo, and the particulars connected with his arrival in this country for that purpose having been publicly noticed by the daily press, Guy's Hospital, at an early hour in the morning, was absolutely besieged by the most celebrated medical and scientific men in the neighbourhood of the metropolis.

Amongst the crowd of medical, scientific, and non-medical individuals who were present to witness the operation, we may enumerate the following:—Sir A. Cooper, Mr. Copeland Hutchinson, Mr. Titus Barry, Mr. Parke (brother of Mungo Parke), Dr. Stroud, Dr. Bright, Mr. Scott, Dr. Pidcock, Mr. Morgan, Mr. B. Cooper, Dr. Hodgkin, Mr. Calloway, Mr. Green, Mr. Travers, &c. At one o'clock Sir A. Cooper entered the operating theatre, and stated, that in consequence of the smallness of its size, and the number who would thus be precluded witnessing the operation, it would take place in the large anatomical theatre, whither a rush was immediately made by those assembled; and although this theatre will hold nearly 1,000 persons, it was crammed in every part within two minutes of the doors being opened. About half-past one Hoo Loo was ushered into the theatre by the sister and nurses of the ward "Luke," with that appearance of good humour in his countenance ("laughing, buoyant, and spirited") which he has been remarkable for manifesting ever since his introduction at Guy's. Indeed, he appeared to interest every one present in his "future fate," and no one betrayed a greater feeling of anxiety (without a particle of nervousness or trepidation) to bring the operation to a successful issue than Mr. Key. This was an anxious moment to all parties. Every one appeared confident of a fortunate termination in consequence of the well-known skill and experience of Mr. Key, and the excellent spirits of the Chinese, which never forsook him until nature became exhausted, as the sequel will prove. It is, perhaps, necessary to observe, that Mr. Key was assisted throughout the operation by Sir A. Cooper, Mr. Calloway, Mr. B. Cooper, Dr. Addison, Mr. Morgan, and other eminent individuals connected with the hospital.

The patient being laid on the table reclining on pillows, the operation was commenced by making two elliptical incisions from the outer margin of the peduncle of the tumour to the spinous process of the pubes on each side. The knife was then carried forward along the upper part of the tumour, so as to raise a flap of integument, which was turned back. A similar incision was then made on each side, and two flaps of integument detached. These incisions exposed some very large subcutaneous veins, which afforded considerable hæmorrhage, and were obliged to be secured by ligatures before the operation could proceed. The neck of the tumour was next detached from above, and the spermatic cords laid bare. The mass of the tumour was finally dissected by a few strokes of the knife from the perinæum, and the lower flaps of the integument being turned back, it became entirely detached from the patient's body.

During the whole of the operation the patient appeared to be unusually affected by the loss of blood, which, in the whole of the operation did not exceed 16 ounces, and entirely venous. The only arteries, besides those of the cords, requiring to be secured, were two small ones at the upper part of the swelling, from which not more than half an ounce of blood escaped. The patient continuing to be faint after the operation was completed, small quantities of brandy were administered, as it had been

during its progress, and time was allowed him, before dressing the wound, to recover. In the meantime, many gentlemen who were present (among whom was Sir A. Cooper) left the theatre, in the expectation that he would speedily rally from his faintness. Fresh air was allowed to blow over him, and warm applications were applied to his feet and chest; but his fainting condition beginning, at length, to excite apprehensions in the mind of the surgeon, brandy was freely injected into the stomach, without producing any re-action of the heart; and it appearing evident, that without some further measures, the heart's action would altogether cease, transfusion of blood was had recourse to, and eight ounces (which were kindly furnished by a medical pupil, whose name we are unacquainted with) were thrown into the vein of the arm. All efforts, however, proved vain, and he sunk.

The question naturally arises, what other steps could have been taken to have ensured success to the operation, and whether any other mode of proceeding would have been attended with less risk? The great danger apprehended by all the surgeons who expressed their opinions on the subject was from the hæmorrhage that might take place; and in the prevention of hæmorrhage the operator adopted every possible precaution by securing each vessel as it was divided, and waiting a considerable period at the successive stages of the operation to allow him to recover, and to have support administered to him. The operation thus became delayed beyond the usual period by the above precaution. Had the operator manifested impatience, or a wish to perform the operation speedily at any risk to the patient's life, he would have justly laid himself open to censure; but his aim was evidently to perform the operation with as much safety and caution as the case would admit. We may, therefore, attribute the death of the Chinese, after the operation was completed, to the shock inflicted upon his nervous system by the operation, and to the loss of a quantity of venous blood, which an ordinarily healthy European would have borne without any dangerous effects. Thus, we regret to state, terminated an operation, upon the issue of which the eyes of all medical men have been turned since the arrival of Hoo Loo in this country. Of one thing the public may rest assured, that no opportunity was omitted which skill and humanity could suggest, to preserve the life of the patient.

The tumour weighed 56lb. avoirdupois, besides three or four pounds of fluid lost during the operation. Its circumference, when detached from the body, was exactly four feet.

An extract from the *Dispatch* of April 17th, 1831.

"The operation consisted in removing from the lower part of the patient's body a tumour, weighing fifty-six pounds, and four feet in circumference. About sixteen ounces of venous blood were lost in the dissection, but the patient seemed to suffer greatly from the loss of that quantity, which would not have dangerously affected a European. Brandy was frequently administered, but failed to rally the action of the heart. Eight ounces, kindly given by a gentleman present, were then transfused into the dying man's veins, but all proved unavailing, and the poor fellow expired.

"Such has been the anxiety to possess some memento of Hoo Loo, that we have heard of one gentleman who offered two guineas for the Chinese hat which he used to wear, and of another who would have freely given double that sum for the dead man's 'queue,' which, like similar appendages to the heads of all the Chinese, measured nearly three-quarters of a yard. The authorities at the hospital, highly to the credit of the establishment, have suffered nothing to be disposed of, and Hoo Loo (who is to be interred in the burial ground of Guy's, on Tuesday next) will descend to his grave without the deprivation of the 'pride of the nation of China'—the tuft on his pericranium."

From the *Museum Catalogue*.

Spec. 1620^{69}.—A portion of an immense tumour weighing fifty-six pounds, removed by Mr. Key from the scrotum of Hoo Loo, a Chinaman, April 9th, 1831.

"He was 32 years of age, and the tumour had been growing ten years; it commenced in prepuce and continued to grow until the whole genital organs were involved, and the tumour measured four feet in circumference. It reached below the knees, but the man's health was good. He came purposely to England for removal of the tumour." (The surgeons in China would not undertake the risk owing to a Chinese maxim which they never failed to put into practice, "The blood of life from him by whom the blood of life is shed."—Ed.)

The tumour consisted of hypertrophied integuments and subcutaneous cellular tissue, constituting the form of disease known as elephantiasis scroti.

Other specimens: 1620^{76}, 1620^{86}, 1903^{94}, 2367^{70}, 2594^{75}, 419^{55}, 139^{10}.

Papers by Guy's Men.

An Address on Inherited Syphilis. By R. Clement Lucas, B.S., M.B. Lond., F.R.C.S.—*British Medical Journal*, 1st February, 1908.

A Post-Graduate Lecture on the Intestinal Perforation of Typhoid Fever. By Lawrie McGavin, F.R.C.S. Eng.—*The Clinical Journal*, 29th January, 1908.

Cases of Colecystectomy. By John D. Malcolm, F.R.C.S., Edin.—*Ibid.*, 22nd January, 1908.

Three Lectures on the Surgical Diseases of Children. Lecture III. By A. H. Tubby, M.S. Lond., F.R.C.S. Eng.—*Ibid.*, 29th January, 1908.

Books, &c., Received.—Angle's Orthodontia, latest edition; Rose and Carless' Surgery, 1907; Halliburton's Physiology, 1907; Hall and Tilley's Diseases of Nose and Throat; Smith's Medical Jurisprudence and Toxicology, 1908; The Practitioner for February, 1908; The General Practitioner (regularly every week).

Notes from Rome.

II.

The Oldest Medical Practitioner in Rome.

BY FREDERIC VICARS, M.D.

Do not suppose that under the above title I am about to give an account of some aged member of our profession in the living flesh. No, the doyen of the profession is the figure of a baby, said to have been carved in the 16th century, by a pious monk, in wood brought from Jerusalem. The doll, known as Saint Bambino, represents the infant Jesus, and is supposed to possess miraculous powers of healing. It is decked with jewels, the gifts of believers. It has a carriage of its own, in which it drives out with its attendants when it goes to visit the sick. Formerly these visits were frequent, but now, I believe, this mysterious "practitioner" is not so much in demand; the march of science, maybe, accounts for this. During the Epiphany, the "Bambino" is on view, and certain ceremonies take place, which are very remarkable. Let me recount my visit to the church in which the little doctor resides.

I enter Santa Maria di Aracoeli by the side door, preferring to ascend the more gentle slope of the steps of the Capitol, to climbing the precipitous flight before the main door of the church. Some hundreds of people are inside. There are two rows of seats down the aisle, with a wide passage between, leading from the main entrance to the high altar. At the last pillar on the right, near the door, is a small wooden platform, with a dirty ragged hanging covering its supports. Round this a small knot of people stand. They are listening to the "Infant preachers." These are children of both sexes—the majority, however, girls—who recite verses and dialogues addressed to or in eulogy of, the "Bambino," whom they have come to honour. It is extraordinary how these children go through their performances. To these little Italians, histrionic gestures are natural. The expressive eyes, the graceful sweep of the hand, the poise of the body, all are appropriate.

Directed by the gaze of these little ones, I look across the church, and see another group gathered in front of a little chapel. I join them. Here, on a raised stage, has been erected a life-size representation of the scene at Bethlehem, the visit of the wise men to the Infant Jesus, In the middle of the group of figures sits the Virgin mother, in blue and red. On her lap she holds a glittering object with the head of a child. I press closer to the iron railing that guards the chapel; a lady lends me an opera glass. The head has the face of a child, with staring brown eyes; short brown curls appear at the sides. On the head is a golden crown, surmounted by a diamond cross. Apparently the figure has neither arms nor legs. Certainly none are visible beneath the closely attached jewellery that is entwined around it from top to toe. Rings, lockets, bracelets, watches, crosses of every description, enamels and necklaces, are massed together. Precious stones of every hue glitter as the flickering candle light catches their facets.

I glance back across the church. The children are still there. A little one in a white shawl is addressing the "Bambino." With her hands pressed to her heart, she is telling the figure, in her high-pitched voice, how she loves it, and how all good children should love it, too. Finally, as I cross the intervening space, she drops a curtsey and retires, with a smile of farewell to the group around the platform.

The onlookers are a motley set indeed. Here stands a mother, with a handkerchief resting lightly on her head, in obedience to St. Paul's injunction that women should cover their heads in church. Next to her, a priest smiling to a fellow priest. Behind these, others of various degree, nationality and sex, a cosmopolitan crew! All are smiling at the performances of the "Infant preachers." One looks in vain for any sign of deeper emotion. As the crowd increases the air becomes oppressive.

I pass out of the church for a breath of fresh air, and light a cigarette. Hundreds of people are swarming like bees up and down the precipitous incline. Hawkers of cheap toys, pictures of the Bambino, cakes and sweets, are yelling out the praises of their wares. Descending to the foot of the steps, I take a couple of snapshots with my camera. Up again I go with the crowd and take up a position immediately in front of the great door. I find myself in a dense throng; all eyes are turned towards a smaller door on the left. A blue banner appears, followed by a procession of priests holding lighted candles. They move impressively and slowly through the crowd, which at every moment is being reinforced from below. Another banner appears, a white one this, and then four soldiers, follow on each side of a priest in white vestments. The latter holds aloft the glittering "Bambino," and all hats are doffed as the procession passes. "Ecco e Bambino!" is the cry on all sides. The crush is awful, but in spite of it I raise my camera and try to "snap" the doll. "Holy Madonna!" gasps out an old crone by my side, shocked by my "sacrilegious" act.

The priests gather near the right hand door, and the "Bambino" is turned towards the city and raised until it towers above the crowd. Then, suddenly, priests and fetish vanish within the church, and the crowd swarms down the steps in a state of wild delight, amidst the yells of the hawkers, who are seeking to make the most of their last chance for the day.

Pass List.

FINAL CONJOINT EXAMINATION, January, 1908.—Medicine and Surgery.—*E. L. Martyn Lobb, H. A. Sanford. Surgery and Midwifery.—*C. H. Marshall, *J. B. Martin. Medicine only.—F. W. Hogarth, F. J. Kolaporwalla, C. E. Price, *H. Stott, *G. F. Syms, B. Wallis. Surgery only.—*H. J. B. Cane, *A. F. W. Denning, *A. L. Foster. Midwifery only.—H. O. Brookhouse, H. B. Carter, L. T. Dean, T. H. Edey, T. Evans, A. E. Lees, P. Seymour Price, C. S. E. Wright.

* Denotes completion of examination.

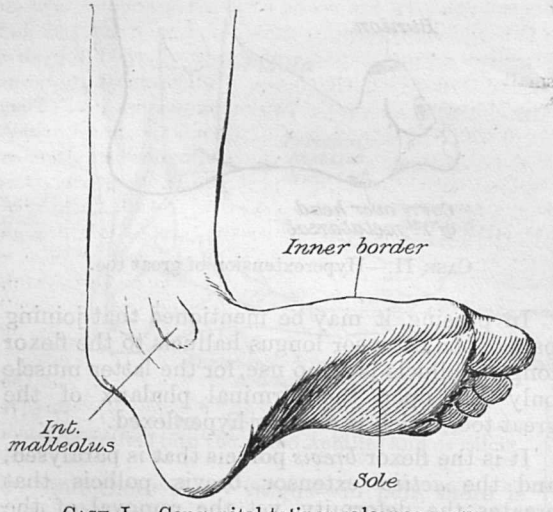
Two Cases Illustrating the Value of Tendon Grafting in Orthopaedic Surgery.

CLINICAL LECTURE BY MR. R. P. ROWLANDS.

GENTLEMEN,—The two little girls which I am showing to-day are interesting examples of the improvements that may be obtained by judicious tendon grafting for some deformities of the feet. These patients have not been brought here because the results are unusually good, but because they presented certain interesting difficulties, from which I have learnt a great deal, and I hope that you also may learn something from them, and especially from my early mistakes.

CASE I. *Left Congenital Talipes Calcaneo-Varus.*—C. F., æt 4½ years, was first seen at the East London Hospital for Children when she was three months old. Manipulation and splinting were tried without much success.

FIG. 1.

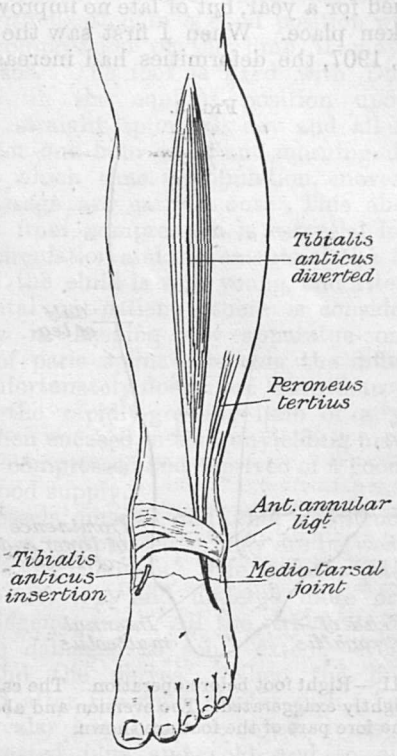


CASE I.—Congenital talipes calcaneo-varus.

Owing to the difficulty of retaining the foot in the corrected attitude, it was fixed in the equino-varus position in plaster of paris. This led to no permanent improvement, and, moreover, it caused wasting of the leg. A few months later the tendo Achilles was shortened, but, in spite of apparatus, it gradually lengthened so much that a year later the deformity was nearly as bad as ever. The child walked with difficulty with the aid of a varus strap and a toe-depressing accumulator (Fig. 1).

In June, 1906, the peroneus longus tendon was divided and its proximal end was grafted into the tendo Achilles, which was again

FIG. 2.



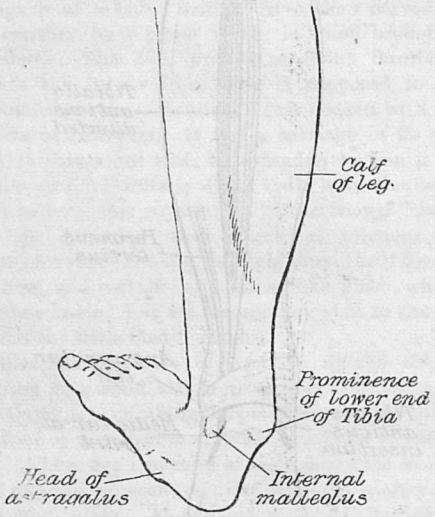
CASE I.—Grafting of the tibialis anticus into the peroneus tertius and cuboid to correct talipes varus. The peroneus longus had been previously diverted into the shortened tendo Achilles.

shortened. The fore part of the foot was forced into a good position by means of a Thomas' wrench. The calcaneus was corrected, but the varus soon returned, in spite of instrumental support. Therefore, in September, 1907, the tibialis anticus was completely divided at its insertion, and joined to a very small peroneus tertius and to the base of the fifth metatarsal bone (Fig. 2). The result is excellent. Now you see the child walking perfectly, without any instruments; but she is going to wear a T varus strap and a toe-depressing accumulator for about a year as a precaution against recurrence of the deformity from stretching of the recently joined structures.

CASE II. *Paralytic Talipes Calcaneo-Valgus of the right foot, with hyperextension of the metatarso phalangeal joint of the great toe. Talipes*

equinus of the left foot.—F. G., æt. 4 years. Before she was two years old the patient had suffered severely from infantile paralysis of both lower limbs. The power returned rapidly at first, then very gradually some improvement continued for a year, but of late no improvement had taken place. When I first saw the child, in May, 1907, the deformities had increased, so

FIG. 3.



CASE II.—Right foot before operation. The calcaneus is slightly exaggerated. The eversion and abduction of the fore part of the foot are shown.

that the child walked with difficulty, and frequently fell and injured herself. Her disability was all the more severe because the two feet were affected with converse deformities, which exaggerated each other. The left foot was in a position of talipes equino-varus, and the right was in the characteristic attitude of talipes calcaneo-valgus (Fig. 3).

Moreover, owing to the deformity of the right great toe, the latter doubled up when the foot was pushed into the boot, and a bunion had developed on the dorsal aspect of the inter-phalangeal joint (Fig. 4).

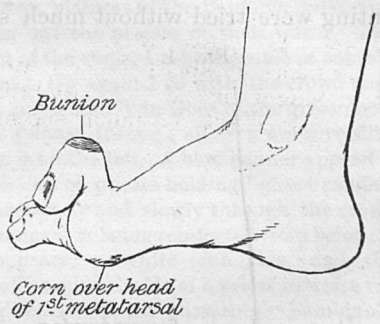
In June, 1907, the patient was admitted into Guy's Hospital for operation.

The peroneus brevis and the peroneus tertius were divided and grafted into the tendo Achilles, but the latter was so thin that one of the dressers thought it to be the plantaris. Therefore the transplanted tendons were given an additional attachment to the periosteum of the os calcis (Fig. 5).

The peroneus brevis was used in preference to the peroneus longus in this case, because it is a more powerful abductor of the foot, so that its diversion tends to correct both the valgus and the calcaneus. Moreover, division of the peroneus longus interferes with the transverse arch of the foot, which is not to be desired in talipes calcaneo-valgus.

For the correction of the deformity of the great toe, the following operation was performed. The extensor longus hallucis was split and lengthened to the required degree, the extensor brevis hallucis, which is inserted into the first phalanx of the great toe, upon its dorsal aspect, was *excised*, because its unbalanced traction is the chief cause of the deformity. The base of the first phalanx was excised, and the cartilage was removed from a portion of the end of the metatarsal bone, to allow fibrous union to take place between the two bones to keep them in a good position.

FIG. 4.



CASE II.—Hyperextension of great toe.

In passing, it may be mentioned that joining part of the extensor longus hallucis to the flexor longus hallucis is of no use, for the latter muscle only acts upon the terminal phalanx of the great toe, which is already hyperflexed.

It is the flexor *brevis* pollicis that is paralysed, and the *active* extensor brevis pollicis that creates the deformity, yet the removal of the extensor brevis pollicis is not enough to correct the deformity, for the bones and ligaments have acquired vicious shapes, and a modified excision of the joint is, in my opinion, the best way of correcting these.

It is probable that in some future cases I shall join a portion of the flexor longus pollicis to the inner head of the wasted flexor brevis pollicis.

The talipes equinus of the other foot was not severe enough to need either tendon lengthening

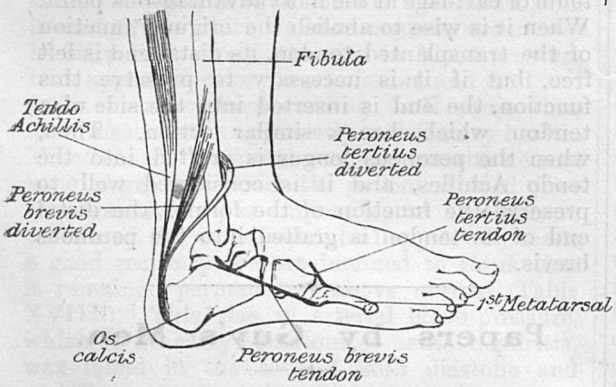
or grafting. The anterior muscles, which had been so weak as to allow the calf muscles to retract, had already recovered, to a great extent, and could be seen to contract. All that was necessary for their more perfect recovery was to allow them a greater range of movement by dividing the tendo Achilles and by preventing the return of the deformity during the later stages of healing.

As a rule, if the heel tendon be not shortened more than one and a half inches, it is not necessary to lengthen it; tenotomy is efficient, and union will occur. Greater shortening usually, calls for tendon lengthening, to avoid non-union, and to promote earlier recovery of function.

When the anterior muscles are inactive or very weak, grafting forwards of some of the posterior muscles is needed in addition to tenotomy or tendon lengthening.

You will see that the results of the three operations, which were performed on the same day, have been good. The fore part of the right foot now takes its due share of the weight of the

Fig 5.



Case II.—Operation: Peroneus brevis and peroneus tertius grafted into the tendo Achilles and os calcis.

body, and there is no valgus—in fact, there is very slight varus from over-correction. You can see the peronei standing out, and pulling upon the heel bone as the patient walks. The great toe is in good position, and the talipes equinus of the left foot has been corrected.

The apparatus which you see is for the right foot, and will be worn for about a year to prevent too much strain upon the newly-joined tendons; it consists of a side iron with a T varus strap and a toe-depressing spring.

At night the left foot is kept at right angles, to prevent shortening of the tendo Achilles, and with the same object the mother stretches the latter daily.

Remarks.

Case 1.—Manipulation alone is of very little use for congenital talipes calcaneus, but combined with fixation in a good position without undue compression of the limb, it may cure mild cases. The foot is fixed with Domette bandage in the equinus position upon an internal straight splint all day and all night, except for one hour night and morning, during part of which time manipulation, movements and massage are carried out. This absolute freedom from compression is essential for the proper circulation and movements of the foot.

When the child is very young, and attending at hospital out-patients, there is considerable difficulty in keeping any apparatus on. A plaster of paris splint gets over the difficulty, but it unfortunately does more harm than good, because the rapidly-growing limb of a young child, when encased in this unyielding material, becomes compressed and deprived of a good part of its blood supply.

The vessels, muscles, and other soft structures suffer most, compressed as they are between the rigid case and the bone. The muscles waste or cease to develop, and undergo more or less fibrous degeneration. All the structures of the limb are damaged to some extent—even the bones and the nerves. When the limb is examined after the rigid plaster case (changed at intervals) has been removed, it is seen to be wasted, blue and cold, and to closely resemble the well-known appearances of infantile paralysis.

I have never used a rigid plaster case even as a temporary measure for any condition of talipes since my unfortunate experience in Case 1; but I have seen many withered limbs which have resulted from this method of treatment, which is unfortunately still used by some surgeons, especially for congenital talipes equino-varus. There is no great harm in using an open plaster splint; but a closed one, allowing no expansion, is much to be condemned. The younger the child and the more rapid his growth, the more marked will be the wasting that may be produced by this ill-considered and ill-advised method of treatment.

Tendon shortening is not, by itself, a very successful operation, nor is it likely to be so upon theoretical grounds. The muscles that terminate in the tendo Achilles, and are usually so powerful, are congenitally weak and ill-developed in these cases, and it can do but little good to shorten the tendon without increasing

the power, for the anterior muscles still overbalance the posterior, so that re-lengthening is very likely to occur, in spite of apparatus used day and night. Combined with tenotomy of the tibialis anticus it may be more effectual.

The division of this tendon has the additional advantage of preventing that conversion of valgus into varus, which extension of the ankle produces when the tibialis anticus is powerful and too short. For talipes calcaneo-varus it is better to divert the tibialis anticus into the peroneus tertius, and thus to change it from an adductor and inverter into an abductor and everter of the fore part of the foot (Fig. 2).

Far better than shortening the tendon of a weak muscle is to reinforce it by some muscle which can be spared. The flexor longus digitorum, or the flexor longus hallucis can be used for this purpose without harm, for the distal end of the divided muscle can be joined to the side of the other, so that all the long flexors of the toes can be preserved.

It is clearly wisest in a case of calcaneo-valgus to divide an abductor like the peroneus brevis, and join it to the tendo Achilles, for this not only gives more power of raising the heel, but also diminishes the valgus. It is important to remember that the peroneus brevis is a better abductor of the foot than is the peroneus longus; therefore it is better to choose the short muscle for transplantation into the tendo Achilles for calcaneo-valgus (Fig. 5).

You will notice that, on the whole, the graftings that have been done for these two patients have concerned muscles whose chief functions are similar, and that their special additional actions are not antagonistic. Thus, the tendo Achilles and the peroneus brevis both extend the ankle joint, although the peronei also abduct the foot. In such cases it is easy to understand that the improvement to be expected from grafting will be seen earlier and will be more complete than when the tendons of antagonists are joined, and this is proved by experience. The brain has less to learn of the new and mysterious effects of its voluntary motor impulses. For this reason, it is always well, if possible, to select muscles with similar actions for grafting. This is not always practicable, but fortunately the brain is capable of readjusting its efforts to a great extent, so that in time an extensor may become a good flexor, and *vice versa*. In one of the cases before you an adductor was grafted into an abductor, and since then it has assumed the function of the latter, while retaining its chief use as a flexor.

A flexor may be split longitudinally, and one half of it successfully grafted into an extensor. The two halves of the same muscles, then, have opposite actions. How are these facts explained? It is all a matter of unconscious education, such as takes place in all of us in infancy. The brain notices and remembers the new effects of the diverted portion of muscles, and soon learns which motor effort produces the new effect. It is, after all, not very strange that the two lateral halves of the gastrocnemius should be capable of opposite actions, for they are supplied independently by separate nerve fibres and cortical cells.

The method of grafting which I generally adopt is as follows:—The tendon to be transplanted is either completely or partially divided as near its insertion as is necessary, and the proximal end is passed through a perforation in the receiving tendon and fixed in position with catgut, which also closes the perforation. For greater security, I often make the diverted tendon form a complete loop round a portion of the receiving tendon. If the latter is very small, the transplanted tendon is sutured to the periosteum or cartilage at the most advantageous point. When it is wise to abolish the original function of the transplanted tendon, its distal end is left free, but if it is necessary to preserve this function, the end is inserted into the side of a tendon which has a similar action. Thus, when the peroneus longus is grafted into the tendo Achilles, and it is considered well to preserve the function of the former, the distal end of its tendon is grafted into the peroneus brevis.

Papers by Guy's Men.

Hints on the Preparation of Skeletons of Vertebrates. By J. A. Bullbrook.—*Microscopical Review*, January, 1908.

The Comparative Anatomy, Gross and Minute, of the Thyroid and Parathyroid Glands in Mammals and Birds. Part I. Illustrated. By David Forsyth, M.D. Lond., M.R.C.P. Lond.—*Journal of Anatomy and Physiology*, January, 1908.

Lectures on the Passage of Food through the Alimentary Canal. Illustrated. By Arthur F. Hertz, M.D. Oxon., M.R.C.P. Lond.—*British Medical Journal*, 25th January, 1908.

A Simple Procedure by which the Risks of Excision of the Rectum can be Materially Reduced and the Removal of Infected Tissues rendered more complete. By W. Arbuthnot Lane, M.S. Lond., F.R.C.S. Eng.—*The Clinical Journal*, 22nd January, 1908.

Some Observations on Arterial Blood-Pressure in Health and Disease.

By H. C. MANN, M.D., M.R.C.P. (Lond.).

III.

Renal Disease.

As is well known, one of the first vital reactions to renal insufficiency, whether the latter be due to acute inflammation or chronic degeneration of the kidney, is a rise in arterial blood-pressure. The points investigated were, the extent of such rise in pressure, the duration of the same, the influence of certain complications, and the influence of certain well-recognised forms of treatment upon the readings obtained. Over seventy such cases have been investigated by us.

All the patients suffering from acute nephritis exhibited signs of general œdema upon admission to the hospital, and, as far as we can tell from the subsequent progress of the cases, and from investigations which we have made in apparently healthy individuals, the rise in blood-pressure had appeared prior to admission, and had not fallen to a minimal reading until some time after discharge in apparently satisfactory health. Whether this minimal reading was the normal arterial pressure which the patient showed prior to admission, it is impossible to say, but, in certain of the cases which had apparently made a good recovery, we are inclined to think that it remained permanently above normal (Table XVIII.). This rise in arterial blood-pressure, which is an early symptom of acute nephritis, was found in the case of both diastolic and systolic pressures. As will be seen from some of the figures recorded, the actual reading varied a good deal; the average pressures were 130 mm. to 150 mm. diastolic, and 150 mm. to 170 mm. systolic. In some of the cases, however, in which, during the first week, symptoms of cardiac dilatation supervened, there was a sudden fall in pressure, as would be expected, and a more gradual fall in cases of pericardial effusion and œdema of the lungs. We saw one case, terminating with œdema of the larynx and laryngeal obstruction, in which the systolic blood-pressure remained high until about one hour before the patient died, when we obtained our last reading (Tables XIX., XX., XXI.). Two cases were found in which valvular disease of the heart, due probably to old-standing rheumatic valvulitis, complicated the trouble. One of these cases, which was fatal, showed the maximum systolic readings which, as we have shown above, are characteristic of the failing heart (Table XXII.).

Patients suffering from chronic tubal and chronic interstitial nephritis are admitted into the wards at such different stages of disease that readings obtained from them varied a good deal, especially as, in many cases, admission had been obtained on account of the various complications which serve to bring about a fatal termination. As is well known, in both conditions the blood-pressure is higher than normal, but in the case of chronic interstitial nephritis both systolic and diastolic pressures are raised enormously, and it is very characteristic that this high level of arterial pressure is maintained almost up to the onset of uræmic symptoms unless the heart has jibbed previously against the increasing strain.

The patient suffering from chronic interstitial nephritis requires an excessively high blood-pressure, in order that renal functions may be effectively carried out in a damaged organ, and so long as the blood-pressure can be maintained sufficiently high for this purpose, and yet not too high to overtax the muscular reserve power of the heart, he will live in comfort. Unfortunately, very often, as a result of over-exertion, too great a strain is thrown on the left ventricle, the blood-pressure falls, and uræmic symptoms appear (Tables XXIII. and XXIV.). It is in maintaining a mid-way position between these two extremes that nitro-glycerin is useful, but it will be found that the power of the drug to lower arterial blood-pressure in chronic Bright's disease passes off very rapidly, so that increasing doses are necessary, until, perhaps, thirty-six or forty minims per day are taken (Table XXV.). We have yet to see, on the autopsy table, a pair of granular kidneys which made any pretence during life to carry out renal functions adequately with a mean systolic blood-pressure lower than 170 mm. More usually the pressure measures 200 mm., and in a considerable number of cases a mean systolic reading of 220 mm. has been obtained with a small wiry, very incompressible pulse, the diastolic blood-pressure measuring not less than 160 mm. As a result of the use of vapour or radiant heat baths, the blood-pressure apparently falls, considerably in some cases, but it soon afterwards rises again, sometimes to a higher level than before (Table XXVI.). Injections of pilocarpine produce immediately a fall in blood-pressure with a subsequent rise,

varying in amount (Table XXVII.). But we do not feel that we have examined a sufficient number of cases to express a definite opinion upon the effect of this drug upon arterial blood-pressure. As a result of the judicious injection of morphia in threatening cases of uræmia, blood-pressure falls with apparent benefit to the patient (Table XXVIII. and XXIX.). In some uræmic cases without obvious signs of heart failure, and characterised by drowsiness or coma, with or without convulsions, we have noticed the blood-pressure to remain high until within a few minutes of death (Table XXX.). As a result of venesection there was a considerable fall in diastolic and systolic pressure as an immediate result, with a slow return to a slightly lower level than the original reading (Table XXXI.).

Albuminuria with pregnancy also claimed attention. When the trouble was due to chronic nephritis, the systolic pressure varied between 180 mm. and 220 mm., and the reading so obtained did not fall appreciably after labour (Table XXXII.). In two cases of eclampsia, which recovered after induction of labour, the blood-pressure in each case began to fall immediately after the fœtus had been removed, and slowly returned, in the course of three weeks, to a level which had remained constant on discharge from hospital. One of the patients was seen three months after labour, and there had been no appreciable change in the blood-pressure (Table XXXIII.).

TABLE XVIII.—Male. Age 23. Acute Nephritis. No complications. Figures refer to pressure measured in millimetres of mercury. Daily estimations. Morning and evening.

	Diastolic.	Systolic.
1. On admission—Evening	124	156
2. Morning	130	160
Evening	132	158
3. Morning	132	164
Evening	136	166
4. Evening	132	162
5. Evening*	130	160
6. Morning	132	160
7. Evening	126	158
8. Evening	120	156
9. Evening	122	156
10. Evening	122	156
11. Three days later. Morning	120	154
12. Three days later	118	148
13. A week later	118	144
14. A week later	116	144

* Albuminuria diminishing. Œdema clearing up. Subsequent recovery.

TABLE XIX.—Male. Age 21. Acute Tubal Nephritis. Cardiac Dilatation.

	Diastolic.	Systolic.
1. (On admission)	140	170
2.	138	164
3.	138	166
4.	138	166
5.*	140	168
6.	134	164
7.	126	150
8.†	124	148
9.	122	148
10.	130	156
11.	124	148
12.	120	144
13.	126	150
14.	130	154

* Patient distressed. Œdema increasing. Drowsy. Heart's action more rapid.

† Physical signs of Cardiac Dilatation.

The readings were taken daily. Subsequently the patient made slow progress. The œdema cleared up, and he was discharged with a trace of albumin in the urine.

TABLE XX.—Female. Age 33. Tubal Nephritis. Daily readings, morning and evening.

	Diastolic.	Systolic.
1. On admission	134	170
2. Morning	134	170
Evening	132	172
3. Morning	134	174
Evening	134	176
4. Morning	130	174
Evening	126	170
5. Morning	122	160
Evening	122	162
6. Evening	120	160
7. Evening	120	156
8. Morning*	120	154
9. Evening	122	156
10. Morning†	122	154
Evening	120	154

* Signs of pericarditis.

† Obvious signs of pericardial effusion.

She subsequently went from bad to worse, general anasarca developed, and death occurred seventeen days after admission.

TABLE XXI.—Male. Age 22. Acute Nephritis. Uræmia. Œdema of Larynx. Anasarca.

	Diastolic.	Systolic.
1. On admission, midday	142	172
10.0 a.m.	140	174
2. 8.0 a.m.	142	176
10.0 a.m.	144	178
12.30 p.m.	142	178
6.0 p.m.	146	180
8.0 p.m.	146	176

Died at 9.30 p.m.

TABLE XXII.—Male. Age 15. Acute Nephritis. Mitral Regurgitation

		Diastolic.	Systolic.	Max. Systolic.
1.	Admission	122	152	150 ($\frac{1}{6}$)*
2.		126	148	
3.		120	146	158 ($\frac{1}{6}$)
4.		118	132	162 ($\frac{1}{6}$)
5.		116	132	160 ($\frac{1}{6}$)

* Indicates one beat in six.

Daily readings. He died about fourteen days later.

TABLE XXIII.—Male. Age 58. Granular Kidney. Daily readings.

		Diastolic.	Systolic.
1.	On arrival	168	200
2.		164	200
3.		166	194
4.		168	198
5.		170	204
6.		174	210
7.		180	220
8.		174	216
9.		178	218
10.*		180	220
11.		178	208
12.†		180	216
13.		178	210

* Patient becoming drowsy.
† Practically unconscious.

He died a few hours after the last reading was taken. An example of blood pressure remaining high. With uræmic symptoms.

TABLE XXIV.—Male. Age 64. Granular Kidney. Fibroid heart, cardiac dilatation. Uræmia. Daily readings.

		Diastolic.	Systolic.	Max. Systolic.
1.		170	206	
2.		172	200	
3.		174	208	
4.		174	210	
5.		172	216	
6.		164	198	
7.	Morning	162	194	
	Evening	160	194	
8.	Morning	152	180	
	Evening	148	176	
9.	Evening	136	164	
13.	Morning	140	162	178 ($\frac{1}{6}$)
11.	Evening	134	158	
12.	Evening	132	158	
13.	Evening	118	144	

An example of falling arterial blood-pressure, due to cardiac dilatation, resulting in renal insufficiency and uræmia. He died of uræmia two days after the last reading.

TABLE XXV.—Male. Age 65. Chronic interstitial nephritis. Cerebral hæmorrhage, resulting in paralysis of left arm and left side of face. Nitroglycerin employed in increasing doses to relieve headache and lower blood-pressure. Daily readings:

	Diastolic.	Systolic.	Max. Systolic.	Dose of drug.
1. On admission	160	178	180($\frac{1}{2}$)	Liq. Trinitrini
			194($\frac{1}{8}$)	♏ii. tds
2.	150	168	180($\frac{1}{2}$)	
3.	150	172	180($\frac{1}{2}$)	
4.	156	176	190($\frac{1}{4}$)	L. T. ♏ii. 6tis.
5.	154	178	190($\frac{1}{4}$)	horis.
6. Two days later	162	180	200($\frac{1}{2}$)	
7. Next day	164	188	200($\frac{1}{2}$)	

TABLE XXV.—*Continued.*

	Diastolic.	Systolic.	Max. Systolic.	Dose of Drug.
8. Two days later	174	196	218($\frac{1}{6}$)	L. T. ♏ii. 4tis.
9. Next day	174	196	216($\frac{1}{6}$)	horis.
10. Next day*	176	198	216($\frac{1}{6}$)	L.T. ♏iij. 4tis.
11. Two days later	154	180	—	horis.
12. Next day	154	176	180($\frac{1}{2}$)	
13. Two days later	165	184	190($\frac{1}{4}$)	
14. Next day	170	196	210($\frac{1}{4}$)	L.T. ♏iv. 4tis.
15. Three days later	152	174	—	horis.
16. Next day	154	176	—	
17. Three days later	160	188	194($\frac{1}{3}$)	
18. Two days later	172	196	208($\frac{1}{4}$)	L-T. ♏vi. 4tis.
19. Next day	140	150	165($\frac{4}{18}$)	horis.
20. Next day	140	150	160	
21. Two days later	160	178	190($\frac{1}{4}$)	
22. Next day	160	178	190($\frac{1}{4}$)	
23. Two days later	162	178	190	

He was discharged relieved. Subsequently readmitted and again relieved. Increasing doses of the nitrite were necessary to relieve headache and lower blood-pressure. His normal blood-pressure is probably considerably higher than is here represented.

TABLE XXVI.—Boy. Age 16. Chronic Tubal Nephritis. Anasarca. Albuminuria. Casts, etc. Readings to show effect of a radiant heat bath upon blood-pressure, taken every five minutes.

		Diastolic.	Systolic.
1.	Usual reading	146	172
2.	Start	144	172
3.	Lights on	144	170
4.	Five minutes	144	172
5.	Ten minutes	144	172
6.	Fifteen minutes	136	168
7.	Twenty minutes	132	164
8.	Twenty-five minutes	126	160
9.	Thirty minutes*	128	160
10.	Forty-five minutes	130	164
11.	Sixty minutes	130	164
12.	Ninety minutes	140	168
13.	Two hours	144	168
14.	Four hours later	146	176

* Lights out.

TABLE XXVII.—To show effect of Pilocarpine Injections. Male. Age 53. Arterio Sclerosis. Hypodermic injection, gr. $\frac{1}{4}$. Pilocarpine Nitrate.

14th November, 1906.

6.25 a.m.	Mean systolic pressure	142
6.15 p.m.	Five minutes after injection	118
6.20 p.m.	Sweating	130
6.25 p.m.		150

15th November, 1906.

6.15 p.m.	Injection. Mean systolic	140
6.20 p.m.		130
6.22 p.m.		125
		(Began to sweat.)
6.25 p.m.		148
6.30 p.m.		170

16th November, 1906.

6.50 p.m.	Mean systolic at	138
6.55 p.m.	Injection 6.53 p.m.	128
7.0 p.m.		125
7.5 p.m.	Began to sweat slightly	138
7.10 p.m.		138
7.15 p.m.		138
8.30 p.m.		125

Injection had very little effect.

TABLE XXVII.—*Continued.*

19th November, 1906.

6.20 p.m.	Mean systolic	146
6.30 p.m.		140
6.35 p.m.		140
6.45 p.m.		146

Injection at 6.15 p.m. No effect.

20th November, 1906.

Injection doubled. Pilocarpine Nitrate gr. $\frac{1}{4}$, at 6.20 p.m.

6.15 p.m.		140
6.25 p.m.		138
6.30 p.m.		136
6.35 p.m.	Sweating well	140
6.40 p.m.		150
6.45 p.m.		155

TABLE XXVIII.—Injection of Morphia. Female. Age about 30. Pregnancy 8 mos. Uræmic symptoms. Eclampsia. Daily readings:—

		Diastolic.	Systolic.
1.	On admission	155	190
	Same evening	154	186
2.	Morning* (10 a.m.)	142	172
	Evening (6 p.m.)	140	172
3.	Morning† (10.15 a.m.)	138	168
	Evening (6.30 p.m.)	138	166
4.	Morning	142	170
5.	Evening	144	170
6.	Evening‡	156	194
7.	Evening	154	192

She died next morning.

* I.M.H. gr. $\frac{1}{4}$, given about 5 a.m.

† Two further injections of morphia, to check convulsions (about 6 a.m.)

‡ Signs of pulmonary engorgement.

TABLE XXIX.—Male. Age 46. Chronic Interstitial Nephritis. Uræmic Delirium. Daily readings, Morphia.

		Diastolic.	Systolic.
1.	Usual reading	180	218
2.	Vomiting, headache, drowsiness	178	222
3.	Much the same	178	220
4.	Delirious (afternoon)*	180	224
	Evening, 6.30	168	190
5.	Morning	166	188
	Evening	164	188
6.	Evening	170	192

He died about three weeks later. Granular kidneys; small. Hypertrophied heart.

* I,H.M. gr. $\frac{1}{4}+\frac{1}{8}$, given about 4.30 p.m.

TABLE XXX.—Male. Age 46. Chronic Interstitial Nephritis. Uræmia. Daily readings for five days before death. Treatment by purging; radiant heat baths.

		Diastolic.	Systolic.
1.	Usual reading	170	200
2.	Morning	168	198
	Evening	172	202
3.	Morning*	172	208
	Evening	172	210
4.	Morning†	170	212
	Evening	172	216
5.	Morning‡	176	222
	Evening	176	218
6.	Morning	178	222

He died half an hour later.

* Increasing headache, drowsiness, sickness.

† Has had one or two slight convulsions—can only be roused with difficulty.

‡ Unconscious. Cheyne-Stokes' breathing. Note that the arterial blood-pressure remained high until within half an hour of death.

TABLE XXXI.—Venesection. Case, "Granular kidney." Male, age 45. Headache. Vomiting. Daily estimations:—

		Diastolic.	Systolic.
1.	Usual reading	168	196
2.	Morning	174	202
	Evening	178	206
3.	Morning	176	200
	Evening	176	200
4.	Morning, 10.0 a.m.	178	200
	12.30 p.m.	178	200
	Venesection 2.15 p.m., one pint.		
	2.30 p.m.	148	176
	5.30 p.m.	150	176
	8.30 p.m.	160	186
	11.30 p.m.	158	188
5.	8.30 a.m.	158	186
	12.30 p.m.	158	180
6.	12.30 p.m.	158	182

TABLE XXXII.—Pregnancy, with Chronic Tubal Nephritis. Female. Age 32. Parturition at 8½ months.

		Diastolic.	Systolic.
1.	On admission	148	180
2.	Second day	150	186
3.	Third day	152	184
	Parturition.		
	Evening reading	148	184
4.	Fourth day	146	178
5.	Fifth day	148	176
6.	Sixth day	144	176
7.	Tenth day	146	178
8.	Fifteenth day	146	180
9.	Three weeks later	146	176
10.	One month	148	174

Blood pressure remains high. Patient subsequently transferred to medical wards. Albuminuria. Casts. Relapsing œdema. Convalescence.

TABLE XXXIII.—Female. Age 35. Admitted for Eclampsia. Morphia administered. Induction of labour.

		Diastolic.	Systolic.
1.	On admission	138	178
	Evening	136	180
	Delivery.		
2.	Morning	140	180
	Evening	144	180
3.	Morning	130	160
	Evening	128	162
4.	Morning	132	164
	Evening	130	166
5.	Morning	132	158
	Evening	132	160
6.	Morning	124	150
	Evening	124	152
7.	Morning	118	146
	Evening	118	144
8.	A week later	116	140
9.	A week later	100	136

Subsequently did very well. Shows the steady fall in blood-pressure as patient recovers. Compare with Table XXXII. Chronic tubal.

(To be concluded.)

Dental News.

A meeting of the Dental Society was held on Friday, January 31st. The President, Mr. F. J. Pearce, in the chair. The minutes of the last meeting having been read and confirmed, Mr. R. M. King presented, as casual communications, teeth showing enamel nodules, erosion and exostosis.

The President then called on Mr. Roberts to read his paper entitled "Dental Fees." In the discussion which followed, the President, and Messrs. Morrel, Hodgson, Samuel, Gibbings, Humm, Edgar, Brangwin, Griffin, W. E. Watson, A. M. Watson, King, Solomon, and Visick, took part.

Number of members present, 44.

A Solbrig's Gold Inlay Apparatus has been presented to the Dental School, and is available for use in the Conservation Room.

A copy of the last edition (1907) of Angel's "Malloclusion of the Teeth" has been added to the Wills Library.

"Smith Turner Exhibition in Dental Mechanics."

The British Dental Association are offering an Exhibition in Dental Mechanics to the value of £30, to be awarded for one or two years, at the discretion of the Committee, and to be tenable at any Dental School.

The first examination will be held at the Royal Dental Hospital, Leicester Square, on April 8th.

Entrance forms may be obtained from the Hon. Sec., British Dental Association, 19, Hanover Square, W., and should be filled in and returned not later than March 1st.

Reviews, etc.

The price of books submitted for review should in every case be stated.

Text Book of Organic Chemistry for Medical Students. By Dr. G. O. Bunge, translated with additions by R. H. Aders Plimmer, D.Sc. (Longmans, Green & Co.).

This book is an attempt to teach organic chemistry from the point of view of the pathological chemist, the substances treated being limited as much as possible to those of physiological and pharmacological interest. The subject is enlivened by discussions, *e.g.*, on the origin of petroleum, and references to the part played by the different substances in physiology and pharmacology. A chapter on the proteins is included. The book thus contains much valuable information in a somewhat concentrated form, and bristles with constitutional formulæ. Its value, however, to a student entirely ignorant of organic chemistry may be doubted, owing to the lack of any attempt to study the simple before the complex. The treatment of the subject is, moreover, entirely theoretical, neither diagrams nor working instructions for a single experiment being given. It is, therefore, somewhat surprising to find a brief appendix by the translator on analysis, qualitative and quantitative. The translation has been excellently done, and the translator's additions to the text are a distinct improvement to the book.

Bilharziosis. By Frank Cole Madden, M.D., F.R.C.S. (Cassell & Co., Ltd.) 3s. 6d. net.

This is a complete monograph on the conditions caused by the presence, in the human body, of the bilharzia worm, *Schistosomum hæmatobium.* The author is the Professor of Surgery at the Egyptian Government School of Medicine at Cairo, and as it is to the observers at this particular school that we owe most of our present-day knowledge of the ravages caused by the *Bilharzia hæmatobia*, one expects a thoroughly comprehensive essay, and in this we are in no way disappointed.

The life history of the worm and the paragraphs on the ætiology of the disease, together with the excellent plates, are most interesting reading, and the author supports the view held by Looss of infection by skin penetration. To this source he attributes the frequency (and non-recurrence) of the disease in the young barefooted native children. The frequency of the disease amongst town dwellers is somewhat diminished since the quality of the drinking water has been improved.

The chapter on pathological changes produced by the *Bilharzia hæmatobia* is illustrated by well-reproduced plates and is exhaustive. Bilharziosis of the urinary system, the intestinal tract, and the cutis are each, in turn, dealt with in a complete aud lucid manner. In vesical bilharziosis the author advises the administration of the liquid extract of Felix mas, together with irrigation. In bilharzial dysentery—with a tumour—the best results have been obtained by laparotomy and simple enterotomy over the site of the lesion.

The author quotes two interesting sites where the *Bilharzia* ova have brought about pathological sequels; one, in the liver, where a periportal cirrhosis may occur, or, as is more usual, an abscess may form, and the second in the lung capillaries, where a form of chronic interstitial pneumonia has been described. Mr. Madden has given us an excellently compiled and lucid account of the disease caused by this member of the group of *Trematodes*, an account which we can heartily recommend to every student of tropical diseases.

Aids to Pathology. By Harry Campbell, M.D. (Baillière, Tindall & Cox.) Cloth, 3s. 6d.; paper, 3s. net.

This addition to the "Aids" series is a compact volume, giving a very brief outline of the general facts of pathology. It is a concisely written account of what of necessity—the compass being so limited—is a mere framework to which students may add the facts that they every day pick up. A text-book of greater scope is of course a necessity, but as an aid to memory this

volume may have its uses. The present day craving, however, of seeking *multum in parvo* is a dangerous proceeding, and should not, we are inclined to think, be pandered to.

Light and X-ray Treatment of Skin Diseases. By Malcolm Morris and Ernest Dare. Pp. 154. (Cassell & Co., Ltd.)

This book is an excellent epitome of the mode of application and results of all the various agents employed in modern actinotherapeutical treatment of dermatological lesions. To us its great charm lies in the true unbiased opinions expressed as regards the efficiency of the agents employed. There is no long list of miraculous "cures" so commonly found in the exploiting of new methods, but rather a well-written and explicit summary of the observations of the authors and others. A prominent place is given to the Finsen treatment and X-rays. Each skin disease which has been treated by actinotherapeutics is discussed.

The plates, from photographs, throughout are excellent, and altogether this little book is by far the best which we have seen dealing with this subject.

Minor Medicine. By Dr. Walter Essex Wynter. (Sidney Appleton.) 6s. net.

This is a treatise in 270 pages on the nature and treatment of common ailments. Dr. Wynter, in his preface, explains the appearance of his book, stating that he considers that the present-day examination systems, together with the customary interception of trifling ailments in the casualty department, so that they seldom reach the physician in the out-patient department, tend to make the student concentrate his attentions more particularly to organic disorders, neglecting the many minor ailments which in general practice he will daily encounter.

Each system is dealt with in turn, and a few headings may serve to show the scope of this treatise: Heart-burn, Bilious attacks, Baldness, Warts, Sprains, etc. A chapter on general health and diet, together with a list of formulæ, conclude what is a well-written, concise, elementary treatise of the commoner minor ailments.

Proceedings of the Royal Society of Medicine. Edited by Dr. J. Nachbar. (Longmans, Green & Co.) 7s. 6d. net.

The second number of the Proceedings of the Royal Society has appeared, and fully endorses the opinion expressed in Passim of the first number. Each component society is devoted a section. The "Proceedings" are printed in large clear type on excellent paper, the whole constituting an excellent production.

Under the clinical section we notice, amongst many other interesting cases, one of a pneumothorax treated by aspiration under X-rays, presented by Dr. Fawcett. Following every case is an abstract of the subsequent discussion.

The dermatological section is prolific in interesting cases, whilst to the electro-therapeutical section Dr. G. Harrison Orton contributes a very excellent paper on the X-ray diagnosis of renal and urethral calculi, illustrated by some remarkably well-produced skiagrams.

The epidemiological section contains a paper read by Dr. Myer Coplans on medical inspection in schools, with an outline of the Gloucestershire scheme. In view of the recent Act this is of special interest.

Many interesting specimens and reports of cases are presented in the sections devoted to laryngology, and obstetrics and gynæcology. The medical section is devoted to the continuation of the discussion on pneumonia and its complications, in which physicians from all the London hospitals are taking part. Each physician contributes to the discussion and presents statistics taken from their respective hospitals, which are remarkable for their completeness. There is also a paper by Dr. Alfred E. Russell on the pathology of epilepsy, in which he submits that the theory of "sudden failure of the cerebral circulation being the immediate factor in the genesis of epilepsy and other convulsive conditions," is worthy of reconsideration. This paper, and the ensuing discussion, we recommend all students to read.

The surgical section gives an analysis of the removal of goitre in 274 cases, by J. Berry, whilst in the pathological section the "Relationship of Avian and Human Tuberculosis" is a contribution which is of no small value. The therapeutics of indigestion, and some notes on the treatment of certain tropical diseases, are the subject matter of the two papers comprising the therapeutical section. The value of the "Proceedings" in their present form to the medical world cannot be overestimated, and the senior student who wishes to keep in touch with the modern trend of his profession in all its branches should make it a golden rule to peruse each number, and, as soon as he qualifies, to become a member of the society itself.

PREPARATIONS, &c., RECEIVED.—Ilford: X-ray plates. Farmamint tablets (Messrs. Wulfing & Co.).

Journals received:—Union Magazine; Medic. Temp. Review: The Hospital; The Clinical Journal; S. A. Medical Record; Middlesex Hospital Journal; Polyclinic; St. Bartholomew's Journal; Durham College of Medicine Gazette; London Hospital Gazette; St. George's Hospital Gazette; New York State Journal of Medicine; Calcutta Medical Journal; St. Thomas's Hospital Gazette; Manchester Medical Students' Gazette; The Prescriber; St. Mary's Hospital Gazette; The Practitioner.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated.*

Notice.

Debating Society.—Ladies' Night.

February 15th, at 8 p.m., Dr. Savage in the chair. Subject: "That in the opinion of this House politeness pays." Proposer, L. Mandel; Seconder, A. W. Ewing. Opposer, M. E. Ball; Seconder, G. W. Dryland.

N.B.—All members of the Clubs' Union are members of the Debating Society.

Sport.

Rugby Football.

GUY'S v. OXFORD UNIVERSITY.

This match was played on the Parks ground, at Oxford, on Wednesday, January 29th. Guy's lost the toss, and started against the wind. Our forwards took the game to the Oxford line, and for the first five minutes Oxford were on the defensive. Eventually the pressure was relieved by a scrum-wheeling manœuvre by the Oxford forwards, and Steinthal, obtaining possession, transferred the game to the other end. In a series of scrummages in the Guy's territory Oxford were now getting the ball, and their three-quarters got going. These opportunities were unproductive, twice forward passes spoiling their tactics, and once a brilliant tackle of Milton by Stringer ending a dangerous movement. The next item of interest was a free-kick to Oxford for "foot-up," but no attempt was made to place a goal, Roberts kicking across. Our forwards now began to assert themselves and took the game to the other end, Mullins starting a dribbling movement, in which he was well followed up. From a scrum close to the line Monaghan made a dash to score, but was checked. Guy's were now heeling the ball well, and our three-quarters made several pretty passing runs, which kept the Oxford backs busy tackling. Stringer was nearly in once, but was crowded too close to the touch line. Monaghan made another attempt to get through on his own, and was held up on the line. The Oxford halves next got away together, and the ball coming out to Lewis, that player kicked across, but Steinthal knocked the ball forward. After a succession of scrummages in Guy's territory, in which our forwards got the ball and attempted wheeling, Williamson at last got possession, and making a clever opening sent Lewis in with a try in the extreme corner. The kick at goal failed, and Oxford returned to the attack, their bad passing, however, spoiling their chances. From a mêlée in midfield, Digby got the ball and, getting clear, ran right in by himself and scored. Lee took the kick, but failed to convert. Half-time followed, the score being three points all.

On resuming, Guy's forwards began to show a great lasting power, and from now till the end of the game had the upper hand of the Oxford pack. In one of a succession of rushes, Archer scored far out on the right; this try was unconverted. Guy's still pressed, but no real openings were made. Eventually Vassal relieved with a long kick, and from a scrum on the Guy's twenty-five line he again obtained possession, and, beating everyone but McEvedy, transferred to Steinthal, who scored in an easy position, Roberts converting. The game was now very fast, but was confined largely to the forwards, Pinching and Crook using their feet well, and Hind making himself conspicuous in more than one line-out. Eventually the ball was taken to the Oxford line, where, for the last twenty minutes, it remained. We were getting the ball out every time, but the Oxford defence seemed impenetrable. Monaghan and Pritchard were playing well, and using every artifice they knew, but there seemed no opening. Jones, who had been doing a lot of work, and was a bit lame, at this point dropped back, and McEvedy came up into the three-quarter line. With only two points difference the game was very exciting now for the small band of Guy's supporters on the touch line. Eventually the ball came to McEvedy, who, first drawing the defence, neatly kicked across from in front of the goal into Stringer's hands; the last-named ran in with no difficulty and scored. This try was not improved on, and no-side coming very shortly afterwards, left Guy's winners of a good game by one point. Teams:—

OXFORD UNIVERSITY.—T. Entwistle (Trinity) (back); H. T. Lewis (Exeter), H. H. Vassal (Keble), F. E. Steinthal (Trinity), and N. W. Milton (University) (three-quarters); W. K. Flemmer (Trinity), and R. H. Williamson (Trinity) (half-backs); G. D. Roberts (St. John's), J. A. Robertson-Durham (University), A. Howard (Christ Church), R. S. Wix (Brazenose), L. C. Blencowe (Queen's) W. W. Hoskin (captain) (Trinity), H. E. Latham (Trinity), and H. A. Hodges (Trinity) (forwards).

GUY'S.—P. E McEvedy (back): W. E. S. Digby, J. P. Jones (captain), H. Lee and L. B. Stringer (three-quarters); P. J. Monaghan and G. B. Pritchard (halves); H. R. Mullins, W. E. Williams, W. G. Pinching, G. R. Hind, H. Archer, H. Moberley, H. Hoby and A. H. Crook (forwards).

REMARKS.—Guy's deserved their success, though the teams were very evenly matched, owing to our superiority forward. The forwards played well to a man, wheeling or heeling without hesitation. The halves showed improvement, and although opposed to a very strong combination in Flemmer and Williamson, were equal to any emergency in defence, and were many times, by their quickness in taking passes on the "blind side," enabled to gain a lot of ground. They should keep their places on their form in this match. Of the three-quarters, Digby showed great pace, but was not always reliable in defence; the others tackled well. The difficulty of making openings against a strong defence

made it sometimes appear that the centres held the ball too long, but on many such occasions passing would have been of little avail. McEvedy played a strong game at back, and when amongst the three quarters was, as above mentioned, mainly responsible for our last try.

Association Football.

The final game in the competition for the London University Cup, founded by the Debating Society, was played on Wednesday, the 29th ult., at Honor Oak Park. Throughout, the games have been somewhat poor, as the first round against the Royal College of Science left us victorious by 7 goals to 1. In the semi-final, 10 goals to nil was the result, whilst in the final we were victorious by 5 goals to 1. The Cup, therefore, is now ours, though it has not yet been allotted a place in the Smoking-room. In the final with the East London College, play on our part was not of a very striking nature, the shooting being distinctly weak. In the first five minutes Whiteley got clean away, and terminated a brilliant run by putting the ball over the bar. A goal was not scored for a quarter of an hour, when Witts succeeded in netting the ball from a difficult position on the right. Later Whiteley scored, in this case also from an angular position, and later one more was added, leaving the score at half-time as 3 to nil.

The second half showed some bad shooting by our forwards, but two more goals were added, whilst the East London people scored one, the game ending 5 goals to 1 in our favour.

The team, considering its strength, did not display any great power either as represented on paper by the score, or in appearance on the field, yet the half line worked well, but tended to sky the ball too much; whilst the combination and power of producing goals seemed inefficient, the occasion warranting a greater success.

TEAM.—C. A. Wood (goal); C. H. Mills, K. H. Hole (backs); P. V. Pedrick, W. F. Denning, P. Harris (half-backs); R. M. King, C. E. Witts, F. W. Whiteley, H. H. Birks, H. H. Glover (forwards).

INTER-HOSPITAL CUP-TIE DRAW.

SENIOR.—FIRST ROUND.—
London v. St. Mary's
SECOND ROUND.— Semi-Final.
Charing Cross v. Westminster
University v. winner of 1st round — Final.
Thomas's v. Middlesex
Guy's v. Bart.'s
JUNIOR.—
London v. Middlesex
Guy's v. Bart.'s
Mary's v. Westminster
Charing Cross v. Thomas's

More Quaint Sayings of Patients, Etc.

An R.N. Story.

Surgeon (to dingy-looking bluejacket, who is being examined for draft to another ship): "H'm, how often do you have a bath, once a week?"

Bluejacket (in an offended tone): "Oh, *no*, sir, I ain't so dirty as all that."

An R.A.M.C. Story.

CLASS DISTINCTIONS IN THE ARMY.

(A TRUE STORY.)

Capt. ———, R.A.M.C., was sitting in his medical inspection room, at 10 a.m., preparing to see the sick men, and treat their complaints as he thought best. The sergeant, in the adjoining room, was marshalling the patients for the inspection, when another man arrived.

"Well, what's wrong with you?" said the sergeant.

"I've got a pain in me abdomen," replied the Tommy.

"Habdomen!" exclaimed the N.C.O., "only horficers 'as habdomens. The likes of you 'as guts!"

The captain laughed abdominally—inwardly, we mean.

Births.

BARBER.—On January 24th, at 45, Friar Gate, Derby, the wife of Dr. Hugh Barber, of a daughter.

CURTIS.—On January 31st, at Alton House, Redhill, Margaret, the wife of Frederick Curtis, F.R.C.S. Eng., of a son.

EDWARDS.—On February 2nd, at Granville House, Bridport, the wife of Charles Edwards, M.R.C.S., of a son (stillborn).

TELLING.—On January 29th, at 29, Park Square, Leeds, the wife of W. H. Maxwell Telling, M.D., of a daughter.

Marriage.

BINNS—JERVELUND.—On February 3rd, at the Parish Church, Linthorpe, by the Rev. J. W. Dales, Vicar, assisted by the Rev. H. E. Wall; H. Theodore Binns, to Constance, eldest daughter of Mr. and Mrs. C. A. Jervelund, The Barns, Linthorpe, Middlesbrough.

Death.

WRIGHT.—On January 17th, at Virginia Road, Leeds, C. J. Wright, M.Sc. Leeds, M.R.C.S., in his sixty-sixth year.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

February.

Sat. 22. 1st XV. v. Old Leysians (Home).
2nd XV. v. Streatham 1st XV. (Surrey Cup).
1st XI. v. Lee (Home).
2nd XI. v. Old Citizens "A" (Away).
Dental Society's Dinner at Trocadero, 6.30 p.m.

Mon. 24. 1st XV. v. Bart.'s.
Clinical Lecture by Mr. Fagge, 1.15 p.m.

Tues. 25. Dental Clinical Lecture by Mr. Dowsett.
Competition in Gym. to pick representatives for Inter-Hospital Competition.

Wed. 26. 1st XI. v. Old Felsted (Home).

Thur. 27. Winner of Bart.'s—Guy's, Rugby Match v. St. Mary's.
Mr. Golding-Bird's and Dr. Hale White's Take-in commences. (Messrs. Cooper and Nutman.)

Sat. 29. 1st XV. v. Park House (Home).
2nd XV. v. London Welsh "A" (Away).
1st XI. v. Surbiton Hill (Away).
2nd XI. v. Surbiton Hill "A" (Home).
Annual Choir Supper in the Reading Room, College. Mr. Fagge in the Chair, 7.30 p.m.
April Appointment List opened.

March.

Mon. 2. Clinical Lecture by Mr. Bellingham Smith, 1.15 p.m.

Wed. 4. Final Cup Tie.

Thur. 5. Mr. Symonds' and Dr. Pitt's Take-in commences. (Messrs. Smith and Rippmann.)

BOOKS, &c., RECEIVED.—A Text-book of Treatment, Part I. Obstetrics and Gynæcology; Sikes on Gout; Cumming's Aids to Surgery; Dental Cosmos and British Dental Journal for February.

Passim.

THE Residents' Dance, which was held on the 7th February, at the Whitehall Rooms, Hotel Metropole, was a brilliant success. About 120 couples were present, just sufficient to fill the magnificent hall without any crowding. Mrs. Cosmo Bonsor, who was accompanied by our much-respected Treasurer, acted as hostess. The Staff was well represented, and there was a goodly scattering of old Guy's men. The music was of the highest order, Mr. Burgess's orchestra coming in for much praise on all sides, not only for the excellence of their playing, but also for the good-natured way in which they responded to the encores, and they were not a few, every dance in the second half of the programme being demanded again. The programme itself was the work of a master, every waltz and two-step being one of the present-day favourites. The management of the Metropole sustained their high reputation in the culinary art, the supper being in every way enjoyable. One little quibble must be allowed, however, the floor, as we heard one fair dancer put it, improving on acquaintance. Early in the evening it was "heavy," then, on receiving attention, it resembled the famous Ski-ing track at Davos. As the evening advanced, however, it improved considerably. Dancing was kept up until after three, and from the opinions one heard expressed on all sides, there can be no doubt as to the unqualified success which has attended the efforts of Mr. Cooper, and the remainder of the Residents.

The importance of an evening of this sort, from a social point of view, we think, cannot be over-estimated. A reunion of old friends and contemporaries under such happy conditions is in every way to be encouraged. True, there are many Dining Clubs, such as the Contemporary and the University, but, nevertheless, such an occasion as this Annual Dance brings together the Present and the Past. We hope, then, that the success which has been the keynote of this year's dance will be borne in mind by, not only men who are still at their studies, but also by any old Guy's man whose eye this Passim note may catch, and that next year there will be a still larger attendance.

We congratulate the Residents, one and all, and if the many "rippings," "toppings," etc., which answered one's inquiry of "How did you enjoy it?" go for anything, they should indeed be pleased with their venture.

On another page will be found the Statistical Tables published annually in compliance with the Regulations of the King Edward's Hospital Fund Committee. The amount of work accomplished in a year will no doubt be a revelation to many. The number of beds now available for use is 608, whilst the average number of patients resident daily throughout the past year was 515·2. The number of admissions for the year was 8,198, and the average length of stay (in days) of patients was 22·8, the Medical cases averaging 33·3 days, and the Surgical 17·6 days. The total number of out-patient attendances was 425,541, which works out approximately at the huge number of 1,360 per diem.

It is interesting to look back at the lists published early in the eighteenth century, and note the growth of the Institution which, by the munificence of one Thomas Guy, was opened in 1725 as a hospital "*To receive and entertain therein poor patients labouring under any distempers, infirmities or disorders, thought capable of relief by physic or surgery, etc.*" The Executors lost no time in carrying out the instructions of the Will, for we read that, even before Guy's funeral, there were admitted 60 patients. During 1728, 1,544 patients were admitted. During 1732 there were as many as 1,800 admittances, and the beds available were 417. In 1738 we find there were 406 patients in hospital on July 27th, whilst the out-patients numbered 16.

Another point of interest, demonstrative of the progress of medicine and surgery, is that the number of deaths per 100 patients admitted in 1732 and 1907 respectively is 15 and 8.

It is with much regret that we have to record the death of Dr. John Henry Galton, whose death at the age of 67, on February 7th, came as a great shock to his many and devoted friends. Dr. Galton was one of the most prominent practitioners of South London, having built up in Norwood an extensive practice, from which he retired at the end of last year. Dr. Galton entered Guy's in 1854, at the early age of 14½ years, and his marked ability soon made itself felt. He took the M.B. (Lond.) in 1861—the year when Guy's men carried off almost all the honours, and gained four out of the six medals, Galton gaining the Gold Medal for Midwifery. He held his house appointments, and in 1862 took his M.D. He later spent five years in China, in Foo Choo, where his reputation as a surgeon was very considerable. In 1870 he returned to England, and, in partnership with Mr. J. Sidney Turner, laid down the nucleus of what developed into a huge practice. He was a Fellow of the Obstetrical Society, and was one of the prime movers in the starting of the Norwood Cottage Hospital. His general interests were wide. He worked for the British Medical Association, and in 1887 was elected to the Central Council as representative of the East Surrey District of the South Eastern Branch. It was Dr. Galton who, in 1892, brought forward successfully the proposal for the admission of women as members of the Association. For the twenty-two years that he was associated with Epsom College he was noted for his indefatigable energy and unselfishness in furthering any scheme which was for the good of the institution. For many years, also, he watched over the interests of the Surrey Medical Society in the rôle of hon. treasurer. His gentlemanly charm, his fine bearing, and his kindness of heart, have

endeared him to all who have ever come in contact with him, and we join the large band of his devoted friends in expressing our condolence and sympathy to his family on their great loss.

The Lees and Rapier Memorial Lecture was delivered at the Town Hall, Oxford, on the 4th February, before a large and distinguished audience. Professor William Osler was in the chair. Mr. McAdam Eccles, the lecturer, dealt in a masterful way with his subject, "The Relation of Alcohol to Physical Degeneration and National Efficiency." Amongst the many interesting suggestions he brought forward were the better education of mothers and fathers, the promotion of research and the dissemination of the results, and the provision of sound recreation.

This latter suggestion is one which, doubtless, if acted upon, would have no small effect in diminishing the amount of sordid drunkenness which is unenviably associated with the English lower classes. The establishment of "winter gardens" and the fostering of the spirit of music, which undoubtedly lies latent in all our classes—for has not no less an authority than Herr Richter lately given material shape to what he has always maintained?—would tend to draw the masses away from what, at present, is their one and only centre of relaxation, namely, the public-house. These and other suggestions, combined with a judicious and attractive course of elementary instruction in hygiene, Mr. Eccles maintained, would do much to keep up that national efficiency which has placed Great Britain in the van of nations.

Amongst the list of lecturers for this year at the Royal Colleges of Physicians and Surgeons, Guy's is well represented. On the 12th of February, Dr. Eyre delivered the Erasmus Wilson Lecture on the Importance (Surgically) of the Pyogenic Activities of the Diplococcus Pneumoniæ. Dr. Eyre is also the Milroy Lecturer, and has chosen for his subject "Militensis Septicæmia." The lectures will be held on the 5th, 10th, and 12th of March, at the Royal College of Physicians. Dr. Herbert French will deliver the Goulstonian Lectures at the same place on the 17th, 19th and 24th of March, the subject-matter being the Influence of Pregnancy on certain Medical Diseases, and the Influence of certain Medical Diseases on Pregnancy.

At the Royal College of Surgeons, on the 9th and 11th of March, the Hunterian Professor, Mr. Ralph Thomson, will lecture on the Anatomy of Long Bones in Relation to certain Fractures. It is to be hoped that Guy's men will bear the dates of these lectures in mind, and that the attendance will be considerably swelled by a goodly contingent from the hospital. All the lectures commence at 5 p.m.

The Annual Choir Supper is to be held on Saturday next, 29th February, at 7.30 p.m., in the College Reading-room, when Mr. Fagge will be in the chair. It is hoped that there will be a good attendance of men of all years. In passing, we would like to point out that the choir does not receive all the support that is its due, also that men should remember that attending is a purely voluntary act on their part, one attendance not entailing an obligatory appearance each week.

We would like to draw the early attention of our readers to the fact that at the final meeting for the session of the Physical Society, to be held on the 12th March, Dr. Frederick Taylor has kindly consented to take the chair. We trust that a goodly assembly of men will be there to welcome the much-respected and popular chairman. The hon. secretary informs us that the latest date for sending in papers for the Treasurer's Prize is March 4th. The prize essay will be read on the occasion of the above-mentioned meeting.

In the Smoking Room will be found a list announcing that the competition for choosing of men to represent the Hospital at the Annual Inter-Hospital Boxing and Gymnastic Tourney, will be held on the 25th February. All men intending to take part in this preliminary competition should inscribe their names on this list as soon as possible.

WE regret to announce the unavoidable delay experienced in the publishing of the Residents' Theatrical Souvenir; we can, however, promise that ere another issue of the GAZETTE, the many subscribers will be in possession of what, in every way, is an amusing and artistic production.

Pass List.

UNIVERSITY OF OXFORD, February, 1908.—Degrees of M.B., B.Ch. conferred.— C. G. Douglas (Fellow of St. John's), N. Flower (Exeter).

UNIVERSITY OF LONDON.—Intermediate Examination in Medicine, January, 1908.—G. B. Cockrem, F. A. Dick, J. A. Edmond, W. E. Fox, T. Lewis Jones, E. A. Penny, R. Stout, *G. Y. Thomson, C. Witts.

* Distinguished in Pharmacology.

UNIVERSITY OF LONDON. — Preliminary Scientific Examination, January, 1908.— Inorganic Chemistry, Experimental Physics and Biology.—H. Webb. Inorganic Chemistry and Experimental Physics. — (*b*) R. Creasy, W. Robinson. Inorganic Chemistry and Biology. —(*p*) W. A. Young. Inorganic Chemistry only.—(*pb*) W. S. George. Experimental Physics only.—(*c*) H. Mather. Biology only.—(*cp*) F. D. Annesley.

c. This candidate has already passed in Inorganic Chemistry.

p. This candidate has already passed in Experimental Physics.

b. This candidate has already passed in Biology.

ROYAL ARMY MEDICAL CORPS, February, 1908.—W. H. S. Burney, A. L. Foster, M. Leckie.

ROYAL COLLEGE OF PHYSICIANS OF LONDON, January, 1908. — Examined for the Membership. — Hector C. Cameron, M.D. Camb., Chas. E. Iredell, M.D. Lond.

Papers by Guy's Men.

Occlusion and the Use of Fixed Appliances in Orthodontia. Illustrated. By Harold Chapman, L.D.S. Eng., D.D.S. Penn.—*British Dental Journal*, February 15th, 1908.

On Migraine. By T. H. B. Dobson, M.D. Lond.—*British Medical Journal*, 8th October, 1908.

A Case of Ruptured Ectopic Gestation Occurring in a Rudimentary Horn of a Uterus Bicornis Unicollis. Illustrated. By H. T. Hicks, F.R.C.S.—*Ibid.*

Excision of the Rectum for Carcinoma. By W. Arbuthnot Lane, M.S. Lond., F.R.C.S. Eng.—*The Lancet*, 15th February, 1908.

Rigor Mortis in the Stillborn. Illustrated. By C. H. Watts Parkinson, M.R.C.S. Eng., D.P.H.—*British Medical Journal*, 8th February, 1908.

On Spleno-Medullary Leukæmia and Splenic Anæmia (Banti's Disease). By J. George Taylor, M.D. Camb., M.R.C.P. Lond.—*Ibid.*

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Wakley-Cooper Libel Suit of 1828.

DEAR SIR,—It is perhaps excusable that a Guy's man, and even the Editor of its GAZETTE, should be unaware of the names of the Staff eighty years ago. Nevertheless, for the sake of exactness, one must ask to be allowed to correct the error in which you have fallen in giving B. Cooper's name as Benjamin. It was Bransby. The result of the trial was by no means an unqualified victory for him, inasmuch as, claiming £2,000 damages, he only obtained £100. I have just been turning up some old volumes of the *Lancet* of that time, and it is interesting to notice that of the great number of students present at the time who signed a sort of testamur in favour of Bransby Cooper, at least two were connected with Guy's when I entered there in 1870—Mr. Hilton as consulting surgeon, and "Teddy" Cock in active work as surgeon. At p. 73 of the same volume of the *Lancet* in which the Cooper case is reported, there is a very good story to the effect that a patient going shortly after, to Bartholomew's, with a hydrocele, came under the care of Mr. Earl, who told him he would soon be cured. The patient was introduced into the operating theatre, which was crowded to excess. When he saw Mr. Earl standing there with a trocar and cannula in his hand ready to operate, "Oh," said the patient, "is this it? No, my lads, I have heard of that Bransby Cooper operation for the stone, in the Borough, and you don't take any stone from me, depend on't. *Besides, my friends don't know where I am.*" He then bolted amidst the loud laughter of the spectators, closely followed by a chimney-sweep who had come to have the scrotum removed for cancer. Neither case was seen there again. Mr. Earl remarked, "That trial has played the devil with our operations."—I am, faithfully yours,

B. JONES, M.D.

Avenue Gate,
Ansdell, Lytham.

P.S.—If there are no early volumes of the *Lancet* in the Library I should be glad to give mine. I have twenty or thirty volumes of the first published.

[We are indebted to Dr. B. Jones for his interesting letter, and must plead guilty to what, seeing we had such a good authority as Sir Samuel Wilks' "History" at hand, was a culpable error.

Apropos of Dr. Earl's patient who thought discretion the better part of valour; in a *Lancet* of slightly later date we find the following doggerel told of a patient who, on hearing his operator was to be Bransby Cooper, is said to have left hurriedly:—

"When Cooper's nevey cuts for stone,
His toils were long and heavy.
This patient greater skill has shown,
For he cut Cooper's nevey."

About this time also were attacks on Key and Bright, and the "critique" on the first number of the Annual Reports was malicious in every way. How different to the esteemed medical "Thunderer's" later estimations of this Annual, when all bitter feelings had passed away.

We thank Dr. B. Jones for his kind offer of early *Lancets*. On consulting the Librarian, however, we find that Guy's is the fortunate possessor of a full set.—ED.]

A Much Needed Reform.

DEAR SIR,—I notice in your last number a letter from an anonymous correspondent, in which he rightly calls attention to the treatment of the illustrated weekly papers by the members of the Club. At the beginning of this year the Committee sanctioned a great increase in the expenditure upon these papers, because it was felt that a larger number of papers would add to the popularity of the Smoking-room. To provide a sufficient number of new leather covers would, however, have entailed a further considerable immediate expenditure. The leather covers at present in use are extremely expensive, and the cheaper ones are too fragile to last. In the meantime, therefore, I would appeal to members of the Club not to remove such papers as have covers from these covers, and to assist in prolonging the lives of the others as far into the week as possible. Had not your correspondent appeared to expect some action from "those in authority"—I quote from his letter—I should not have ventured to point out that ordinary care and cleanliness on the part of a minority of the members will prevent the soiling and mutilation of which he complains.

—Yours truly,

H. CHARLES CAMERON,
Hon. Sec.,
Students' Club.

The College,
Guy's Hospital, S.E.,
February 9th, 1908.

Dental News.

A meeting of the Dental Society was held on Friday, February 14th, the President, Mr. F. J. Pierce, in the chair.

The following casual communications were presented:

Models showing a case of acro, by Mr. F. Holcombe Fuller.

A four-rooted upper molar, by Mr. Morell.

The President then called on Mr. Morgan to read his paper on "Environment: Its physiological and pathological effects upon the Teeth and Jaws."

Mr. Morgan said that Environment might be taken to mean the aggregate of the external conditions which affect existence. He then pointed out how the existence of certain dental factors, such as large canines or massive jaws, though of use to a primitive man, became less and less useful as evolution progressed, and hence they tended to disappear.

The effect of environment on certain pathological conditions was next discussed; for example, in the production of dental caries, Rose's observations with regard to the prevalence of caries in districts deficient in lime salts were given: the effect of artificial foods and modern methods of cookery were also commented on.

A point which was brought out was that formerly European populations were agricultural and lived in scattered habitations, whereas now they live in crowded towns under insanitary and unhygienic conditions. The effect of this is seen in the extent to which modern children are subject to rickets, tubercle of the exanthemata, as well as to dental caries.

The effect of modern industries leading to conditions such as phosphorous necrosis, and the prevalence of caries in workers in felt hat, rabbit skin, and tin plate works was shown.

Extracted teeth, and also a case from a large biscuit factory, were shown, to exemplify the effect of this work in producing dental caries. In conclusion, the importance of dental surgeons being appointed to systematically care for the teeth of persons so employed was emphasised

In the discussion which ensued the President and many of the members took part. The number of members present was forty.

The next meeting will be held on Friday, March 13th, when a paper will be read by Mr. H. G. Spain.

The British Society for the Study of Orthodontia.

This is a new society which has been formed for the study of Orthodontia. Its headquarters are at the rooms of the Medical Society of London, at 11, Chandos Street, Cavendish Square, W. It was felt that there are so many problems still unsolved relating to the etiology of dental irregularities and their correction, that special work is needed for their elucidation.

The object of the society is to assist in arriving at scientific facts which, when collated, may lead to the prevention as well as the correction of the trouble. Its membership is not confined to any one cult of so-called Orthodontists, but is extended to all those who take a scientific interest in the subject.

The society should appeal to Guy's men, inasmuch as members of this school are well represented on the executive, *i.e.*, President: Mr. Badcock. Vice-President: Mr. Montagu Hopson. Librarian: Mr. J. E. Spiller. Curator: Mr. Hubert Visick. Mr. E. R. Tebbitt is also a member of the Council. The Secretary is Mr. J. Lockett, from whom further particulars may be obtained.

In noting a month ago the appointment of an assistant curator to the Dental section of the Museum, we regret there was a slight error made in saying that the Dental section has been entirely re-arranged. What should have been expressed is that Mr. G. Hunt is now assisting Mr. Dowsett in renovating the comparative anatomy specimens as well as amplifying the Dental surgical cases.

Guy's Physiological Society.

A paper was read before this society on January 13th by Mr. J. A. Bullbrook, the subject being "An Enquiry as to the Influence which acquired characters exert on Organic Evolution and Heredity."

The most difficult of all problems concerning Evolution and Heredity is that of variation, a solution of which would lead us even as far as the origin of life. Variation is an inherent part of that adaptation of the organism to surrounding influences, which is life itself. This, however, does not necessarily imply adaptation of means to an end, which is the term as used in the germ-plasm theory, but a receptivity of impress from extraneous forces. Hence the contention that acquired characters have an influence on variability, and so on evolution and heredity.

Weismann's theory leaves much to be explained, although it has been so readily accepted, to the detriment of valuable research. His definition of acquired characters is well defined, viz., "Those which are not performed in the germ, but which arise only through special influences affecting the body or individual parts of it." His theory, however, is open to the same criticism as he applies to Darwin's theory of Pangenesis—it explains everything, or nothing. Moreover, he admits that his experiments were based on *a priori* theory. The only essential difference between the two theories, Pangenesis and Germ-plasm lies in this, that whereas in the one hypothesis the "gemmules" are provided by, and so directly acted upon, by *all* the cells of the body, in the other the "idants" are derived only from the germ tissue of the body, and only influenced in some indirect manner, left unexplained, by the other constituents of the organism. Yet we are asked to believe that the "idants" perform essentially the same functions as Darwin's gemmules." Weismann's writings present many inconsistencies, each of which affords a means of attacking the main theory.

Given that acquired characters are inherited, an organism which has acquired a new character is essentially a new variety. The theory of transmission of acquired characters reasonably accounts for variation; it is simple and consistent and explains the majority of cases. As Weismann points out, there are only two ways in which such variation could conceivably occur in the germ-plasm in consequence of a corresponding somatic variation. We must assume either that definite tracks exist throughout the body along which each somatogenic variation might be transferred to the germ cells and plasm of which it would produce a corresponding change, or that "gemmules" are given off from every somatic cell, and are conveyed to the germ cells through the vascular system, or by some other means. Whilst admitting that this is correct, we need not necessarily agree further that both hypotheses are inadmissible, as Weismann maintains: by analogy, the second hypothesis would seem to be quite sound. These and many other considerations show that we must not assume, in the present state of our knowledge, the impossibility of the somatic cells taking a definite share in the construction of the germ.

Mr. Bullbrook's conclusions resulted from a careful line of argument, the basis of which was independent of other authors, although the conclusions themselves were similar—a significant fact. He also quoted examples which had come under his own observation.

Guy's Hospital Debating Society.

Annual Ladies' Night.

The Annual Ladies' Night of the above Society was held in the College Smoke Room on February 15th. Dr. Savage, the President of the Society, occupied the chair, and about seventy ladies and members were present.

There being no private business of importance,

Mr. A. R. THOMPSON opened the debate by moving, "That in the opinion of this House politeness pays." After explaining that he was the fifth reserve for the proposer of the motion that evening, Mr. Thompson plunged at once *in medias res* by declaring that politeness did *not* pay the gas-bill. Of all nations, he believed the Welsh to be the most polite (a wave of incredulity passed over the House), but he had never yet heard of a Welshman who paid. Definitions were sure to be asked for, but he would not go further than to say that by "politeness" he meant politeness, and by "paying," paying. He amplified this, however, by defining politeness as the paying attention to people's vanity, or better feelings. In a railway carriage, if a fellow-passenger adjusted the window without first asking his permission, he promptly dealt with the other window as it suited him; but if a fellow-passenger (rarely met) did ask his permission, he was glad to answer by a gracious "With pleasure." Therefore, in that case, politeness paid. But politeness should not degenerate into sycophancy on the one hand, or condescension on the other. The speaker concluded by agreeing with Scott rather than with Thackeray, that "the disagreeable man gets everything he wants."

Mr. BALL opposed. He feared that he and his "poor friend," the seconder of the opposition, were the most unpopular men in the room that night. He then read two remarkable telegrams relating to the proposer of the motion, and a third one was passed to the chairman, who communicated part of it to the House, remarking that he was sorry anyone had gone to the expense of one-and-sixpence for no better object. Mr. Ball, resuming, pointed out the dogmatic wording of the motion, that it was not qualified by a "sometimes," or an "often," so that it must be assumed to mean that politeness always paid. To show that it did not always

pay, he related the story of the old gentleman and the young curate, who, owing to their mutual politeness, remained on the platform while their train steamed out of the station.

In the fields of politics and commerce, the speaker declared, politeness had absolutely no place, and certainly did not pay. In such fields, self-advertisement, which was the very opposite of politeness, held sway. And, looking at the lower animals, we saw that the impolite lion was the king of beasts.

For these reasons, therefore, and for others either forgotten or never thought of, he opposed the motion.

Mr. EWING, seconding the motion, modestly confessed that alliteration appealed to him, as it did to all people with a liberal education. Such phrases as "Ta, ta!" and "Pip, pip!" he, personally, found specially attractive. In Webster (quoting the exact page and paragraph) he found that politeness meant smoothness, so he proceeded to develop this point. He then stated that he tried to be polite when he paid, and politer still when he was obliged to defer payment. He next subjected the House to a series of puns. Our reporter unfortunately missed the context, but something about a "horrid plight" was heard to be followed by howls of anguish. Mr. Ewing pointed out the value of politeness in four professions—to burglars, doctors, medical men, and statesmen—and he concluded by relating the next speaker's conversation with a Miss Jones.

Mr. MANDEL seconded the opposition, and, true to his post, started ungallantly by addressing "Mr. Chairman, and gentlemen—and ladies." He had referred to Annandale, and, not to be outdone by the last speaker, also quoted the exact page and paragraph, where he found that politeness meant polish, which was very akin to varnish, which brought us within reach of physiology. He gave a twentieth-century translation of some Greek writer on materia medica, in which politeness was dealt with as a drug.

Referring to the suffragettes, he asked whether the proposer of the motion would be willing to give up his seat in a tram or train to one of them, and he pictured the riot which would have taken place had Mr. Asquith been polite to them.

The CHAIRMAN, in placing the motion before the House for discussion, mentioned the interesting fact that the words "politeness" and "polite" can nowhere be found in Shakespeare. He also related the story of the three public school boys, illustrating the attitude towards politeness of Eton, Harrow, and Rugby, respectively.

Mr. SCHLESINGER proved, by a simple process of reasoning, that the motion was false:—Politeness is generally a form of hypocrisy; hypocrisy is a vice; no vice ever pays; ∴. Politeness does not pay. Q.E.D.

The SENIOR SECRETARY said that modern politeness was only a form of old-time chivalry, which was, unfortunately, too little seen now; and he considered that the comfort obtained in days of chivalry more than counterbalanced the money earned by the want of politeness of the present day.

Mr. LEVINSON was surprised at the effrontery of any one opposing the motion, and pointed out that a knowledge of politeness was only to be gained by practical experience of it. He dealt with politeness in relation to the restaurant, the dance, the examination, and showed in each case that "unpoliteness" did not pay.

Mr. WALKER strongly believed that politeness paid in the wards. And then politeness was one of the main attributes of a gentleman, and as such was to be striven after.

The JUNIOR SECRETARY quoted the death-bed apology of Charles II., that he was afraid he was an "unconscionable time a-dying," as the very pattern of politeness, which, he thought, must have paid.

Mr. GIBBINGS told a story of politeness in the humbly circumstanced.

Mr. MORRIS supported the motion, but desired a definition of "pay." Was it to imply material or moral advantage?

Miss BALL said she felt sure that politeness shown by a gentleman to a lady in giving up his 'bus or train seat always paid; but where it was a case of a crowd boarding a tram, politeness did not pay, for the tram was apt to get full up with the impolite.

The CHAIRMAN asked if there were any other ladies in the room (who would be willing to contribute to the debate).

Miss ADAMS, of Bedford College, emphatically declared that there were other ladies in the room (acquiescent applause).

Miss MOORE, also of Bedford College, urged that, so far from costing nothing, politeness sometimes cost a very great effort.

Mr. REEVE related an incident in his personal history, where impoliteness had been eminently profitable.

The CHAIRMAN now called upon the opposer to reply.

Mr. BALL cited a case where politeness had been the ruin of a man in an examination. Any reference to the attributes of a gentleman was irrelevant and unnecessary, as that fact was understood, the question being—did politeness pay? The impolite were the people who got on; to them fell the exciting times and the extraordinary coincidences which gave a zest to life.

Mr. THOMPSON, replying for the motion, also pointed out the irrelevancy of Mr. Walker's remarks. He was afraid that the responsibility for it rested on the proposer. (A voice, "Unfortunately.") Because he was proposing the motion, he must not be thought insincere; a signpost might indicate the road without following it. He thought the death of Charles II. more polite than his remark which had been quoted. Impoliteness had been proved not to pay; therefore politeness did pay.

The CHAIRMAN now put the motion to the House, when it was carried by a large majority, only ten voting against.

Mr. THOMPSON proposed a vote of thanks to Dr. Savage for occupying the chair, and Dr. Savage briefly replied. The House then adjourned for refreshments.

Pupils' Physical Society.

CONSTIPATION.

A DISCUSSION was held on Wednesday, the 19th instant, on "Constipation," Mr. Norman Flower in the chair. The opening papers were read by Mr. Cox on the Physiological Aspect, Mr. Macalister on the Etiology and Medicinal Treatment, and Mr. Cooper on the Surgical Treatment.

Mr. Cox said: When I was asked to contribute to this discussion some remarks on Constipation, more particularly from the physiological point of view, the obvious doubt which at once occurred to the mind was whether the subject had any physiological aspect; it seemed rather like speaking of the pathological aspects, say, of the normal liver. It is true, constipation is co-extensive with civilisation, and the geographical distribution of the purgative pill corresponds to those regions of the globe where the foot of the white man has trod, so that constipation may perhaps be looked upon as one of those abnormalities which, like baldness in middle-aged men, are almost normal.

The much-discussed surgical treatment of chronic constipation has been largely responsible for awakening an interest in the subject in the mind of the physiologist; but so far practically not much exact work on the subject has been done, for the factors at work are so various, and the conditions obtaining in the human being are so difficult to realise in the animal, that the scope for experimental investigation is extremely limited.

No cases of constipation, except those of lead poisoning, seem to be due to a deficient activity of the small intestine. For the present purpose, therefore, we may confine our attention to the alimentary canal from the ilio-cæcal valve onwards. It may be useful to summarise briefly the events which normally take place in this part of the intestinal tract so far as they are known.

Some four and a half hours after a meal the intestinal contents begin to pass through the ilio-cæcal valve, and they occupy, roughly, another four and a half hours in the process. When they enter the large bowel, these intestinal contents are quite fluid; the greater part of their water is absorbed by the cæcum and ascending colon. Digestion does not normally take place to any great extent in the large intestine, and such as occurs is mainly bacterial, but the presence of numerous glands in the intestinal wall suggests that this part of the gut may possess greater digestive powers than it is usually credited with.

Four and a half hours after their passage through the ilio-cæcal valve, the intestinal contents have reached the splenic flexure, and have attained the consistency of fæces. The accumulation of this material in the descending colon and sigmoid flexure gives rise in due time to a feeling of fulness in that region, and the sequence of events comprised under the term defæcation begins to take place. Increased abdominal pressure, due to a voluntary contraction of the diaphragm and abdominal muscles, with closure of the glottis, forces down the fæces, so that the rectum becomes distended, and some material enters the normally empty anal canal. Two conditions give rise to a spinal cord reflex, whereby the whole, probably, of the large intestine is stimulated to peristalsis, and, the anal sphincters being at the same time relaxed, defæcation is completed.

Such being the normal condition, we have to inquire into the abnormal condition of constipation. In the first place we need a definition of the word. It cannot be maintained that the absence of a daily evacuation constitutes constipation any more than that the absence of micturition at five-hourly intervals constitutes retention. In some people, two or three days, or even longer intervals, between successive evacuations of the bowels seem to be quite normal. For want of a better definition, I am taking "constipation" as applying to those cases where definite improvement to health follows treatment whereby more frequent openings of the bowels are obtained.

The causes of constipation in these ordinary, not definitely pathological, cases, may be broadly classed under three heads:—

1. Nervous.
2. Muscular.
3. Dietetic.

1. In the first class, the most potent factor productive of constipation is neglect of the calls of nature; in other words, neglect of the normal sensory stimulus to defæcation when it is felt. Two cases of chronic constipation investigated by Dr. Hertz were found to be almost entirely due to the bad habit of postponing defæcation having been acquired during childhood. In such cases the constipation, unless treated, becomes progressively more marked, since a constantly increasing stimulus becomes necessary to produce the defæcation reflex, and consequently the sigmoid flexure becomes distended and loses its normal muscular tone.

Another bad habit, which is a fruitful source of constipation, is postponement of defæcation owing to hurry or any mental excitement. In these cases the normal automatic action of the centre in the lumbar cord is inhibited by psychic influences from the higher parts of the nervous system.

2. The second class of causes includes those due to muscular inefficiency. The squatting position of the savage is held by many to be preferable to the ordinary posture adopted during defæcation in the water-closet of civilisation. The pressure of the thighs against the abdominal walls is supposed to assist the abdominal muscles, and the posture is also said to straighten out the sigmoid flexure, and so allow pressure on the fæces to be employed to better advantage than in other cases.

Weakening of the abdominal wall, such as occurs in women after many pregnancies, and also in the senile and obese, is frequently a cause of constipation.

Weakening of the muscular intestinal wall is probably caused by chronic overloading of the gut in constipation, so that the condition becomes progressively worse.

3. The initial cause of constipation in a great majority of cases is probably an injudicious diet. A physiologist, well known to us all, was asked, during his *viva voce* in Medicine, by Dr. Bristowe to write a prescription for a case of constipation. Instead of writing a prescription, the candidate described, at some length, the hygienic measures as to diet, exercise, and so forth, that he would recommend to the patient. "But I want a prescription," said Dr. Bristowe. Still the candidate declared he would not give drugs, and although he ultimately succumbed to the exigencies of the occasion and wrote a prescription, he was probably none the less certain of the supreme importance of the hygienic measures which he had advocated.

The dietetic aspect of the subject is one of growing importance, for there is a curiously widespread idea in the lay mind that feeding in the near future may be reduced to the assimilation of a few highly-nutritive manufactured tabloids, whereby the despised animal pleasures of eating and drinking may be reduced to a minimum, and as little time as possible may be wasted, as they call it, in the preparation and eating of food.

Some such idea pervades many minds, even now. The importance of taking a diet sufficiently bulky from cellulose and other indigestible material, which acts as a natural purgative, and renders the fæces of correct consistency, is far too seldom realised. This principle of bulky intestinal contents favouring normal action of the bowels is the basis of a German treatment of chronic constipation, which consists in the administration of agar-agar with the food.

Many people, also, take far too little liquid; cold water—a physiological purgative—they shun like poison. Similarly, the value of sugar in he same direction is not realised. Pulpy fruits, the natural combination of sugar and water, and green vegetables, consisting of cellulose and water, are valuable parts of a diet.

Such are the sins of omission in diet; on the other hand, the abuse of tea, coffee, and drugs, and the taking of too highly proteid or starchy diet, are also frequent causes of constipation.

I fear I may have been trespassing on the ground of other speakers this evening, but, as I have mentioned, the subject is not physiological, and the amount of exact work done in connection with it is extremely small. I had hoped that something might be known of those "toxic" substances which are so frequently mentioned in connection with constipation as being responsible for the familiar pigmentation, loss of fat, graveyard smell, etc., but I can find nothing in the literature on this subject beyond these vague descriptions. It is not even certain which of the urinary constituents may be taken as a measure of the amount of putrefaction going on in the intestine.

I have not referred to the surgical treatment of constipation, but this passage from the Huxley memorial lecture in 1904, by Sir William MacEwen, would, I suppose, sum up the attitude of the general body of physiological opinion in regard to that procedure:—

"When a child is born in this country some consider it necessary that he be circumcised. A few years later the tonsils are removed; this is followed by the removal of the pharyngeal tonsil; a few years later the appendix becomes an ever-increasing terror, which is only allayed when that organ has been placed in a glass jar. Next, there is openly expressed discontent about the alimentary tract. Some are persuaded that there is an intestinal whorl too much, and that this extra whorl requires to be 'short-circuited.'"

In conclusion, I fear that the teaching of physiology in regard to constipation comes to nothing more than a platitude—that prevention is better than cure. Every effort ought to be made by inculcating hygienic habits and a rational diet in homes and schools to prevent the development of a condition of chronic constipation. The treatment of such cases as have already unfortunately developed is the province of the clinician.

ETIOLOGY AND MEDICINAL TREATMENT.

Mr. MACALISTER said: There is nothing new under the sun. In olden times, constipation was thought to be the cause of, and purging the remedy for, all human ill. No doubt, but we are much wiser people than they, but nine-tenths of our latter-day treatment is on exactly similar lines. Ignorant as they were, they can hardly have known less of the symptoms of constipation than we do.

What are the symptoms of constipation? If one consults text-books on the subject, one finds much good writing on this point. If one reduces this to its lowest terms, and translates all the hybrid polysyllables, one learns that the symptoms of constipation are inflammation of the colon, pain, and diarrhœa. With this may be associated irritability of temper, dulness of intellect, depression of spirits, and headache. This is quoted from the most recent text-book. It is also to be found in a most ancient book of wisdom.

The local symptoms of constipation depend on the site of the accumulation. Sigmoid accumulation will give rise to a catarrhal condition of the bowel, with a persistent scanty diarrhœa—distension with overflow. The neighbouring pelvic organs may be involved, and such troubles as enuresis, or dysmenorrhœa result. Cæcal accumulation may lead to severe local inflammations—perityphlitis, appendicitis, and such-like.

That the site of the accumulation is, in the vast majority of cases, the sigmoid, has been shown by abdominal palpation, rectal examination, sigmoidoscopy, and, recently, by skiagraphy. In traversing the large intestine, a most indispensable organ, the fluid fæces give up the bulk of their watery contents, and come to rest as a firm mass in the sigmoid.

The causes of the arrest of fæces in the bowel are best considered in three groups—lack of natural stimulus; diminished expulsive power; and increased resistance.

The natural stimulus to the bowel comes from its contents—the food with its undigested residues, and the bile. If the tendency of present-day education is to ordain an almost perfectly digestible diet, it should also ordain that the intestinal muscle react to a nominal stimulus. Those advanced persons who live exclusively on Plasmon biscuits—and masticate *them* for two hours—must assuredly become mightily constipated.

Diminished expulsive power is a result of enfeebled voluntary muscles. Our arboreal ancestors must have had fine abdominal muscles; many of their present descendants are barely equal to the effort of closing

the glottis. Sedentary folk who have no abdominal musculature worthy of the name are frequently constipated. Pathological conditions such as ascites, or overstretching, from tumours or repeated pregnancies, bring about the same result.

Increased resistance may be due to hardness of the fæces; this is perhaps rather an effect than a cause, but in any case it will aggravate the condition. There are also a number of other conditions which will cause increased resistance. It would be well, perhaps, if a distinction could be made between functional constipation, which is a disordered habit, and organic constipation for which a gross anatomical cause exists. The state under discussion ought to include the whole region between health and complete intestinal obstruction, and every possible gradation therein. Such gross anatomical causes are kinkings and twistings of the gut, adhesions and constrictions, retroflexions and other misplacements of the uterus and its appendages; enlargements of the prostate; dislocations of the recto-vaginal septum following labour. It may safely be said that many cases of chronic constipation are in reality due to one or other of these conditions.

The indications for treatment from pathology are twofold—first, to remove the accumulation, and secondly, to correct the habit. From etiology, the indications are to increase the defective stimulus, to improve the tone of the muscles, and to diminish resistance.

The removal of accumulation leads to the vexed question of purges. Two or three new purges make their appearance every year, and yet they are not really new. An elegant preparation is synthesised from coal tar and dignified with some such classical word as Exodin. Its active principle is probably also to be found in a herb that was much in vogue while our ancestors wore tails. Senna and Figs and their properties were well known to the Pharaoh of the Exodus. A near relation of Cascara was officially recognised in the army of Alexander the Great.

It must be admitted that elegance was not an attribute of our forefathers' prescriptions. The following comes from a work dated 1656:—

"Take half an ounce of Senna, one spoonful of Aniseeds, half a dram of Licorith, one spoonful of French seeds, a few raisins of the sun with the stones picked out, boyl them together in a quart of fair running water; let it boyl till one half be consumed, and add to it one dram and a half of Diaphenicon, and shake the same well together, and let the party which desireth to purge drink a pritty quantity thereof every morning, fasting, blood warm, and it will purge him without causing any sickness. This is an excellent good purge for all manner of disease."

Senna, Rhubarb, Colocynth and Aloes were all well known at this period. It was customary to give them all together.

A preparation known as Regulin is now much in vogue in Germany. It consists of agar-agar with a small quantity of cascara added. In the intestines the agar-agar imbibes fluid and swells up considerably, thus supplying the mechanical stimulus needed.

Enemas, especially oil enemas, are always to be preferred to purges. Small oil enemata retained for four hours or so will often be satisfactory when all else fails.

When it comes to correction of the habit of constipation, it is time to have done with drugs and rely on diet, mode of life, exercise, massage, and the like.

The introduction into the diet of brown bread, marmalade, and fruits will, in the majority of cases, make a vast difference. Such a diet supplies the natural stimulus which has hitherto been lacking. In some German health resorts a special diet is prescribed.

The second indication from etiology was to increase the expulsion power by improving the tone of the abdominal muscles. This is secured by exercise—real exercise, not merely a half-hour sauntering constitutional, but hill-climbing or digging, or some such play.

Massage may be either performed by the patient or by a professional. If the patient be intelligent he can probably do this better than any professional. Ten minutes' massage in the morning before rising is often effective. Some people roll a cannon ball around the region of their large intestine, and claim they derive benefit therefrom.

The third indication is to remove undue resistance to evacuation, and this may sometimes be a justification for surgical procedure. Sometimes, too, the cause of increased resistance may be a prolapsed and tender ovary. If in such a case massage and exercise be indiscriminately prescribed, the constipation will get worse, but a morphia suppository will have an excellent and speedy result. Enterospasm, if there be such a condition, may be similarly treated.

A great cause of constipation is the ridiculous superstition that after breakfast is the only time for evacuation—probably the most inconvenient half-hour in the day, full of social and train-catching awkwardness; last thing at night is obviously the time. This is especially the case with sufferers from piles.

After the bowels have been opened they can duly rest, so that the congestion in the piles may subside. Such a reform would also cure a great many cases of insomnia by removing the stimulus of a loaded rectum.

Lastly, it must remembered that a daily action of the bowels must not be too eagerly pressed. There are many folk in whom the bowels open normally twice, sometimes even once, a week. Cases have been described in which a fortnightly evacuation has been consistent with long life and perfect health. Such ones should learn their own periodicity, and would rebel against the slavery of a nightly purge. Injudicious drugging may set the engine racing, and do incalculable harm.

Mr. COOPER emphasised the fact that only in the advanced cases of constipation, where the lives of the patients became a misery to them, was operative interference necessary. He went on to discuss the various operations which had been performed—freeing adhesions, ileo-sigmoidostomy and complete colectomy—and pointed out that the last was the best.

A discussion followed.

Mr. CAMERON put forward a plea for more careful classification of the forms of constipation, and thought that this would give a better basis for treatment than at present existed.

Mr. WHEELER asked whether it was proved that the adhesions were due to the constipation.

Mr. LEE ATKINSON discussed the question of the large intestine, and quoted Metchnikoff to show it had none.

Mr. WALKER stated his experiences from a practical knowledge of patients subjected to excision of the large bowel. He had seen pigmentation disappear. After the operation he had seen no dilatation of the small intestine, but adhesions were, as a rule, present, and the patients suffered from pain.

Messrs. LAIDLAW, MOLLISON and HERTZ also spoke.

The meeting adjourned at 9.45.

The next meeting is on March 7th, Mr. Goodhart in the chair. Clinical Cases will be shown.

Tonsillitis.

NOTES FROM A CLINICAL LECTURE BY Mr. F. J. STEWARD.

Gentlemen,—I propose to deal briefly to-day with the subject of Tonsillitis and its results from the surgical point of view, and shall not, therefore, dwell on the causes, symptoms and treatment of the various forms of the condition in a general way.

Acute tonsillitis, more especially the follicular form, frequently causes an inflammatory process in the tissues surrounding the tonsil—the condition known as quinsy. Quinsy is not really suppurative tonsillitis, as it is often called, but a peritonsillitis or an infective cellulitis involving the tissue immediately adjacent to the tonsil.

This cellulitis is due to infection spreading from the tonsil, and behaves quite as cellulitis does elsewhere,—it may undergo resolution or it may suppurate, or in rare cases in which the infection is particularly virulent, sloughing may occur.

Infection may spread from the tonsil in various directions, so that a quinsy does not always occupy the same position. As a general rule, the spread takes place from the upper part of the tonsil; in fact, from that somewhat shut-in piece of the tonsil that lies in the supratonsillar fossa. The result is a swelling in the substance of the soft palate immediately above and in front of the tonsil. This is what is commonly understood by the term quinsy.

Much more rarely the spread takes place from below and in a direction either backwards or forwards, giving rise to an inflammatory mass or an abscess in the wall of the pharynx in the former case, or in the base of the tongue in the latter. These conditions are sometimes spoken of as pharyngeal quinsy and lingual quinsy. They are serious conditions, because they are particularly liable to cause respiratory obstruction either from œdema or direct pressure. The following case will serve to emphasize this point. Some years ago I was asked by the late Dr. Bryant to see a boy who was admitted with a sore throat, a high temperature, and considerable laryngeal obstruction.

On examining his throat, follicular tonsillitis, but no membrane, was seen, and on passing the finger into the fauces I felt a bulging below the right tonsil, which was extremely tender.

He was put lightly under an anæsthetic, and on more thorough examination I felt an elastic swelling of some size situated below the right tonsil and spreading downwards beyond the reach of the finger towards the back of the larynx. The swelling was opened with sinus forceps, and a quantity of stinking pus let out, with immediate relief to the laryngeal obstruction.

In the common form of quinsy there is a red, tense, tender swelling, involving one half of the soft palate, associated usually with œdema of the uvula, and enlarged tender glands behind the angle of the jaw. Frequently, also, there is considerable trismus, so that it may be most difficult to see what is the matter.

There is always great dysphagia, and usually pyrexia and general illness; these toxic symptoms, however, vary considerably, and depend upon the virulence of the infection.

In order to make a diagnosis and to decide whether pus is present, the best plan is to stand behind the patient and to carefully pass the right index-finger into the mouth. A definite swelling will then be felt in the soft palate, usually very tender, elastic, and fluctuating, but occasionally quite hard and not so tender. In the former case pus is present and must be let out, in the latter resolution may take place.

The best method of opening a quinsy will depend upon its extent. If small, and localized immediately above the tonsil, a pair of scissors curved on the flat is the best instrument. One blade is pushed upwards immediately above the tonsil into the swelling, while the other passes in front of the upper end of the anterior faucial pillar. The scissors are then closed (Vide Fig. 1).

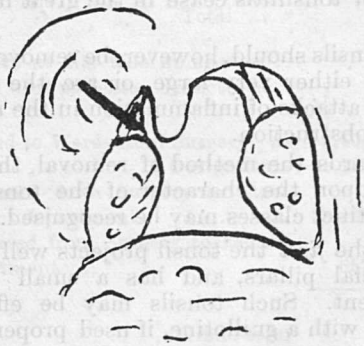

Fig. 1.

The abscess is thus not only opened but efficient drainage is secured, because the cut in the anterior faucial pillar gapes.

If, however, the quinsy is large, it usually tends to burst through the anterior surface of the soft palate, and this is the best site for an opening. This must *not* be made with a knife, or it will quickly close, and pus re-collect. The

best instrument is a sinus forceps, which should be sharply pushed into the abscess, opened, rotated through a right angle, and withdrawn open. This will make a large opening, ensuring satisfactory drainage and rapid cure.

There is a condition which is sometimes spoken of as chronic quinsy, the patient complaining that he has a quinsy which bursts, and is no sooner well than another attack occurs.

This is nearly always due to a quinsy which bursts into the supratonsillar fossa and refills again owing to inefficient drainage, and on examining with a probe you will be able to find an opening in the supratonsillar fossa leading upwards into the soft palate. The condition may be cured by opening up the cavity with scissors, as I described a moment ago (Vide Fig. 1).

I propose now to consider the question of removal of tonsils for recurrent attacks of inflammation.

In the first place, with regard to children who are brought to you for repeated sore throats, and whose tonsils are not extremely large, but who are suffering from nasal obstruction due to adenoids. Do not be in a hurry to remove the tonsils in such cases, for it is often quite unnecessary, for this reason. The adenoids result in mouth breathing, which is the direct cause of the repeated tonsillitis, the tonsils being infected from the inspired air. Under normal conditions the passage of the inspired air through the nose renders it sterile. If the adenoids are removed nasal respiration is re-established, and the attacks of tonsillitis cease in the great majority of cases.

The tonsils should, however, be removed when they are either very large, or are the seat of repeated attacks of inflammation in the absence of nasal obstruction.

As regards the method of removal, this must depend upon the character of the tonsil, and three distinct classes may be recognised.

I. In the *first* the tonsil projects well beyond the faucial pillars, and has a small base of attachment. Such tonsils may be efficiently removed with a guillotine, if used properly.

(The method of using the guillotine was here demonstrated.)

II. In group two the tonsil is attached by a broad base, and projects little beyond the fauces; in fact, it lies largely behind the anterior faucial pillar.

These tonsils require to be partially enucleated before the guillotine is applied. This may easily be accomplished in the following manner. A pair of scissors curved on the flat is taken, one blade passed above the tonsil behind the anterior faucial pillar, and the other blade passed in front of the pillar, and the base of the pillar then divided (Vide Fig. 2).

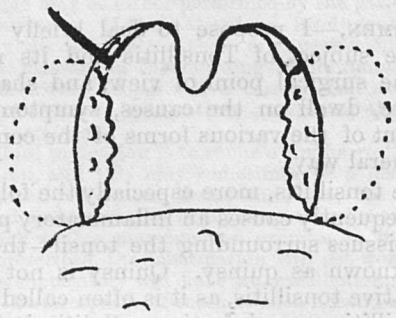

Fig. 2.

The divided palato-glossus retracts and exposes the upper end of the tonsil. With the closed scissors the tonsil can be now quickly and easily enucleated from its bed in a downward direction until the upper half is free. The guillotine is then applied and the tonsil removed.

III. In the last group of cases the tonsil is small and flat, almost hidden behind the anterior faucial pillar, and will be found to be formed largely of deep crypts, which often contain cheesy material. The only satisfactory way of removing tonsils of this description is to punch them away piecemeal. Many forms of tonsil punch are made for this purpose. In my opinion, they are all unsatisfactory, because they are not sharp enough. The instrument that I use for the operation is Hartmann's conchotome, which, as you see, is a sharp punch, and will rapidly cut away the tonsil.

Appointments.

Civil.

CHISOLM, R. A., M.B., B.Ch. Oxon., has been appointed Assistant Physician to the North-Eastern Hospital for Children, Hackney Road, Bethnal Green.

INGRAM, Percy C. P., M.B., B.S. Lond., has been appointed Resident Medical Officer to the Shoreditch Infirmary.

Naval and Military.

Staff-Surgeon M. P. Jones, R.N., has been appointed to the *Attentive*, Staff-Surgeon E. S. Tuck, R.N., to the *Foresight*, and Staff-Surgeon R. F. Clark, R.N., to the *Victory*.

Captain L. Humphry, R.A.M.C., has been appointed Specialist in Advanced Operative Surgery at Poona.

Statistical Tables of Patients treated, etc.

AS REQUIRED BY KING EDWARD'S HOSPITAL FUND.

IN-PATIENTS.

	1906.	1907.
1 Number of beds available for use...	602	608
2 Average number of patients resident daily throughout the year	520.3	515.2
3 Number of In-patients in the hospital at beginning of year ...	501	535
4 Number of In-patients admitted during year	7,946	8,198
5 Number of In-patients in hospital at end of year	535	506
6 Average number of days each patient was resident	23.9	22.8

OUT-PATIENTS.

1 Total number of new Out-patients	147,521	131,138
2 Total number of Out-patient attendances (including 33,808 Dental attendances in 1907)	396,547	425,541
A Number of patients on books at beginning of year	1,173	1,450
B Number of Casualty patients included in No. 1 above	91,062	76,721
C Number of Casualty attendances included in No. 2 above ...	190,104	186,864
D Number of Maternity patients included in No. 1 above (attended at home)	3,766	3,704
E Number of Maternity patients included in No. 1 above (attended at Hospital)	95	95

ANALYSIS OF STATISTICAL TABLES.

IN-PATIENTS.

Number of admissions—Medical ...	2,379	2,690
Surgical ..	5,567	5,508
Total ...	7,946	8,198
Number of deaths—Medical ...	483	495
Surgical ...	251	194
Total ...	734	689
Deaths due to accident	87	95
Brought in dead	23	27
Analysis of number of In-patients under treatment—		
Relieved	6,704	7,076
Discharged (unrelieved) ...	474	462
Died	734	689
Remaining January 1st ...	535	506
Total ...	8,447	8,733
Average number of patients in daily residence—Medical	249.1	248.3
Surgical	271.2	266.9
Total ...	520.3	515.2
Average stay in hospital (in days)—		
Medical cases	38.1	33.3
Surgical cases	17.7	17.6
Medical and Surgical cases	23.9	22.8

OUT-PATIENTS.

Patients in Surgery Registers ...	91,162	94,086
General Out-patients—Medical ...	14,957	14,912
Surgical ...	7,105	7,847
Special departments—		
Dental—Extractions	11,526	7,690
Conservative Treatment	5,208	5,447
Obstetric	1,400	1,740
Ophthalmic (Mr. Eason)	3,242	3,919
(Mr. Ormond) ...	2,495	2,322
Aural	1,393	1,782
Skin	3,273	3,980
Throat	2,094	2,108
Orthopædic	—	113
Maternity patients	—	3,704
Total ...		149,650

To arrive at the true number of individual Out-patients, deduct as under :—

Admitted to Wards from Surgery ...	3,405	
" " " Out-patients	1,147	
Transferred from Surgery to Out-patient department	13,403	
Transferred from Surgery to Dental department	557	
		18,512
Grand total		131,138

February, 1908.

PERCY A. PEALL, M.B., B.S., on the occasion of his leaving for Southern Rhodesia, was presented on January 31st by the combined Cricket and Tennis Clubs of Goodmayes, Essex, with a handsome solid silver fruit dish and an illuminated address, in appreciation of his services in the Cricket Field and Tennis Courts.

Some Observations on Arterial Blood-Pressure in Health and Disease.

(Concluded.)

BY H. C. MANN, M.D., M.R.C.P. (LOND.).

IV.

ADDISON'S DISEASE.

There have been three cases of this disease in Guy's Hospital during the past two years, in which the diagnosis has been verified at the autopsy. In all these cases arterial blood-pressure was certainly very low, though in one of the three which died shortly after admission, the actual value was not obtained. In the case here recorded (Table XXXIV.) the patient's symptoms were absolutely typical; he was nearly always to be found curled up, asleep, under the bedclothes. When he was awake, it appeared to be too much trouble for him to speak or to feed himself. Occasionally he would answer questions in a drowsy, dreamy way. His maximum systolic blood-pressure never measured more than eighty millimetres of mercury at any time during the month in which we were examining him. The mean systolic pressure at times was as low as forty-eight millimetres. It was quite impossible to estimate the diastolic pressure. The patient was a young fellow of twenty, well grown, strong and healthy prior to the onset of his fatal illness.

TABLE XXXIV.—Male. Age 20. Addison's Disease. This is the lowest series of blood pressure readings which we have obtained. It was quite impossible to estimate diastolic pressure.

Nov., 1907.		Mean Systolic.	Max. Systolic.	
12th.	6.0 p.m.	65 mm.	70 mm.	(1/5)*
	9.45 p.m.	60	65	
13th.	5.30 p.m.	60	70	(1/8)
14th.	12 noon	60	70	(1/8)
15th.	1.0 p.m.	60	70	(1/8)
	6.30 p.m.	58	68	
18th.	12.50 p.m.	70	80	
	5.50 p.m.	68	76	
19th.	5.15 p.m.	65	72	
	9.45 p.m.	62	70	
20th.	1.0 p.m.	48	—	
21st.	6.30 p.m.	58	70	
22nd.	3.0 p.m.	60	70	

* Indicates one beat in five.

He died a few days later. Figures indicate pressure in millimetres of mercury.

EXOPHTHALMIC GOITRE.

Twelve cases were examined; eight of them were women. In all of them the diastolic pressure was apparently lower than normal; there were occasional irregular maximum readings. The systolic mean pressure was high, but it was only sustained for a very small part of the cardiac cycle. So that the readings obtained were similar to those noted in aortic disease.

TABLE XXXV.—Female. Age 26. Symptoms of Graves' disease had been present for two years. Daily readings.

	Diastolic.	Systolic.	Max. Systolic.
1.	84	150	
2.	86	148	
3.	82	152	
4.	80	152	
5.	84	152	
6.	84	152	
7.	84	150	
8.	86	152	
9.	88	154	
10.	84	154	
11.	84	154	
12.	86	156	
13.	84	160	174 (1/8)
14.	82	156	
15.	84	154	
16.	84	156	
17.	84	156	
18.	82	156	
19.	82	154	
20.	84	154	

TABLE XXXVI.—Female. Age 26. Symptoms of Graves' disease had been present for three years. Daily readings. Treatment. Rest in bed. Belladonna.

		Diastolic.	Systolic.	Max. Systolic.
1.	Evening	88	142	164 (1/8)
2.	Evening	90	146	—
3.	Evening	94	148	—
4.	Morning	88	148	—
5.	Evening	92	140	164 (1/8)
6.	Evening	90	148	160 (1/8)
7.	Evening	90	148	—
8.	Evening	90	146	—
9.	Three weeks later	96	136	—
	Evening	96	138	—
10.	Evening	94	136	—
11.	Evening	96	136	—
12.	Evening	96	136	—

LOBAR PNEUMONIA.

A few observations were made upon cases of lobar pneumonia. Certainly in one of the cases examined, the arterial blood-pressure remained high until within about half an hour of death. The patient was unconscious and suffering apparently from general pneumococcal poisoning. (Table XXXVII.) One case of pneumonia complicated by mitral disease is here given. The subject was a young male adult, and the blood-pressure readings merely seem to confirm the opinions given elsewhere as to the changes

which may be expected with a failing heart. (Table XXXVIII.) In other cases in which there was obvious right-sided cardiac dilatation with pulmonary congestion, though the systolic mean pressure was high (160 mm., 165 mm., 170 mm. were recorded), such pressure was only maintained for a very small part of the systolic period of the cardiac cycle, and was therefore, we may suppose, of little benefit to the patient. (Table XXXIX.) Strychnine, when administered hypodermically, invariably produced a rise in arterial pressure with steadying of the heart's action. From what we have seen with adrenalin, as used in the wards, the effect produced is variable, and quickly passed off, so that the same improvement in the pulse was not noticed. With caffein, the effect was variable also, but when a rise in blood-pressure was obtained it was more usually sustained than was the case with adrenalin. A good many cases, of course, were in such a serious condition that we were unable to obtain any consecutive estimations at regular intervals.

TABLE XXXVII.—Male. Age 28. Double pneumonia. Pneumococcal septicæmia. Death.

		Diastolic.	Systolic.	Max. systolic.
1.	5.30 p.m	116	144	—
	9.30 p.m.	120	150	170 ($\frac{1}{10}$)
2.	8.30 a.m.	118	146	170 ($\frac{1}{10}$)
	10.0 a.m.	122	148	—
	12 noon	120	148	—
	4.0 p.m.	120	150	—

Died half an hour later.

TABLE XXXVIII.—Male. Age 28. Lobar Pneumonia. Mitral regurgitation. Daily readings,

		Diastolic.	Systolic.	Max. Systolic.
1.	Evening	92	126	150 ($\frac{1}{8}$)
2.	Morning	90	130	148 ($\frac{1}{8}$)
3.	Evening	90	124	148 ($\frac{1}{10}$)
4.	Evening	88	124	148 ($\frac{1}{8}$)
5.	Morning	90	124	148 ($\frac{1}{8}$)
	Evening*	90	126	146 ($\frac{1}{10}$)
6.	Morning	90	126	146 ($\frac{1}{8}$)
	Evening	90	126	148 ($\frac{1}{8}$)
7.	Evening	94	124	146 ($\frac{1}{10}$)
8.	Evening	98	126	150 ($\frac{1}{12}$)
9.	Evening	98	128	144 ($\frac{1}{12}$)

Subsequently did well.

TABLE XXXIX.—Male. Age 38. Alcoholic. Double Pneumonia. Right-sided Cardiac Dilatation. No valvular disease.

		Diastolic.	Systolic.
1.	Evening	102	162
2.	Morning	98	160
	Evening	96	160
3.	Morning	100	160
	Evening	96	164
4.	Morning	94	160

He died later in the day. The systolic reading is high, but it is not sustained for more than a short part of the systolic period. Compare readings with those from cases of aortic regurgitation.

TABLE XL.—Female. Age 32. Lobar Pneumonia. Strychnine injections.

		Diastolic.	Systolic.
1.	Mid-day	102	124
	5.30 p.m.	94	118
	8.30 p.m.	110	134
	11.30 p.m.	110	140
2.	10.15 a.m.	112	140
	12.30 p.m.	110	138
3.	4.30 p.m.	110	138
4.	6.0 p.m.	110	140

At 6.0 p.m. on the first day (fourth of the disease), owing to increasing cyanosis, strychnine injections were ordered. I.S.H. m. v. 3tis horis.

PREGNANCY.

The final series of observations which we have to record are in association with a physiological state, and not with a disease. We have already mentioned certain alterations which may be noticed in connection with chronic tubal nephritis, and the toxic nephritis of pregnancy. It was obviously necessary to find out if there was any tendency for alterations in arterial pressure to occur in cases of normal labour. Two dozen consecutive cases of pregnancy in Queen Victoria ward were examined. In some of them no difficulties were anticipated or experienced during parturition; in others, though trouble had been anticipated, none was experienced. In all of these cases a slow rise in both systolic and diastolic pressure was found, which reached a maximum with the onset of the first stage of labour. After labour blood-pressure is apparently subnormal for a time, and then there is a slow rise to normal level during the early stages of the puerperium. While labour is in progress the blood-pressure between the pains is apparently low, but there was considerable difficulty in estimating its value while uterine contractions were taking place, owing to muscular movements in the extremities. Apparently it rises considerably. In one case of mitral stenosis with pregnancy, very low readings were obtained, and some œdema of the feet, with bronchitis, developed, but the patient subsequently rallied and did quite well. Ergot, when administered for gynæcological purposes, either subcutaneously or by the mouth, does not appear to produce a general arterial rise in blood-pressure. (Tables XLI., XLII.)

TABLE XLI.—Pregnancy. Labour. Patient aged 26. 2 para. Morning and evening readings. Labour normal.

		Diastolic.	Systolic.
1.	Evening	98	126
2.	Morning	98	126
	Evening	100	126
3.	Morning	98	130
	Evening	108	130

TABLE XLI.—continued.

		Diastolic.	Systolic.
4.	Morning - -	110	136
	Evening - -	116	140
5.	Morning - -	114	144
	Evening (6.0 p.m.)	120	150
	(8.30 p.m.)	118	150
	(11.0 p.m.)*	122	150
6.	Evening - -	100	126
7.	Two days later -	94	126
8.	Two days later -	94	124

* First stage of labour. 9.30 p.m. Child born at 4 a.m. next day.

TABLE XLII.—Patient aged 28. 3 para. Pregnancy and labour normal.

		Diastolic.	Systolic.
1.	Morning -	94	120
	Evening -	96	120
2.	Morning -	96	120
	Evening -	96	122
3.	Morning -	100	128
	Evening -	100	128
4.	Morning -	110	134
	Evening -	112	134
5.	Morning -	110	136
	Evening* -	110	138
6.	Evening -	90	120
7.	Morning -	92	120
	Evening -	90	120

* Labour. First stage. Child born six hours later.

CONCLUSIONS.

1. Arterial blood-pressure, both systolic and diastolic, varies much in different individuals, at different ages, with rest and exercise, in health and disease, at different hours of the day.

2. The difference between systolic and diastolic readings, in most healthy individuals, measures about thirty millimetres of mercury.

3. In the case of individuals who are "untrained," vigorous muscular exercise is accompanied by a rise in the systolic arterial pressure, with high irregular readings, which are maintained during only a small portion of the cardiac systolic period. The diastolic pressure remains low, or rises very slowly. Similar changes, less marked in degree, were found in the case of individuals who had taken exercise immediately after meals. The phenomenon of "second wind" is accompanied by a rise in diastolic arterial pressure, with a disappearance of the high irregular systolic readings above mentioned.

4. When there is valvular disease of the heart and compensation fails, the diastolic blood-pressure falls steadily, and irregular maximum systolic readings appear. If the valvular disease is of long standing, and has been accompanied by hypertrophy of the left ventricle, the mean systolic pressure may remain normal or above normal for some time, but this level is only maintained for a very small fraction of the systolic period, and there is a rapid fall with the onset of cardiac dilatation or pericardial effusion.

5. Blood-pressure readings taken after a cardiac patient has been allowed to get up for the first time, show a rise in the value of the mean systolic pressure, which rise is smaller as improvement in general health is maintained. If a fall in diastolic pressure is registered, it is an indication that the patient has been allowed to get up too soon.

6. The appearance of the presystolic bruit in cases of mitral stenosis is always accompanied by a rise in the mean diastolic pressure, and until the mitral mid-diastolic bruit of the failing heart has given way to the mitral presystolic bruit, such improvement does not take place.

7. In cases of myocardial degeneration, both systolic and diastolic blood-pressures are of low value, and there is not the same tendency to high, short, irregular systolic "kicking."

8. Venesection.—When the quantity of blood removed from the arm, in cases of advanced mitral failure, was eight ounces or under, there was practically no change noticed in either diastolic or systolic pressure. When the quantity of blood removed was ten ounces or over (up to twenty-three ounces) the immediate effect of the venesection was a rise in the mean systolic pressure, a steadying of the heart's action, with a disappearance of irregular maximum systolic readings. After about four hours' time a rise was also noticed in diastolic arterial pressure.

9. Strychnine and digitalis, when administered in cases of heart disease, produced greater effects upon arterial blood-pressure, as cardiac stimulants, than any other drugs which we have seen employed. Nitro-glycerin, in large doses, is very useful for lowering blood-pressure in cases of secondary cardiac angina, but increasing doses are necessary if the effect is to be maintained.

Morphia frequently produces a rise in diastolic blood-pressure, with a steadying of the heart's action, and a similar improvement may be noticed after the use of hyoscine for aortic delirium.

10. With acute nephritis, but more especially with chronic interstitial nephritis, both diastolic and systolic pressures are enormously increased, the former relatively more than the latter. This high reading is maintained, in many cases, even after the onset of uræmic symptoms, and may only fall a few minutes before death. If the left ventricle has given way against the

constant strain, blood-pressure falls towards normal, and, in any case, a rapid fall in arterial pressure indicates the closing scene.

11. The onset of the first stage of labour is preceded by a rise in both systolic and diastolic pressure.

12. The lowest readings recorded of any of the cases investigated were obtained in a case of Addison's disease.

The subject-matter of the foregoing articles has been obtained as a result of some observations made by myself upon patients in Guy's Hospital during the past two years. For permission to investigate the cases I am much indebted to the physicians and surgeons to the hospital, and especially to Dr. Frederick Taylor, who, while senior physician, and later as consulting physician, has helped me with many kindly criticisms and comments.

H. C. M.

Reviews, etc.

The price of books submitted for review should in every case be stated.

An Index of Treatment. By various writers. Edited by Robert Hutchison, M.D., F.R.C.P., and H. Stansfield Collier, F.R.C.S. (John Wright & Co., Bristol.) 21s. net.

The publishers of the present volume may be congratulated upon the success which has attended its issue. We believe that its sale has been very great, and that the first edition has already been exhausted. On the whole we are not surprised. The form which has been adopted, where the matter is arranged in alphabetical order, from Abortion to Yellow Fever, is probably by far the most convenient for a work upon treatment. It permits of ready reference. At the same time it entails a good deal of repetition, and emphasizes the impossibility of writing upon treatment apart from pathology. The article upon anæmia well illustrates this point.

Especially admirable are the articles which deal with methods of treatment other than that by drugs. It is in this respect that so many books upon treatment have been found wanting. Moreover, while it is almost impossible for a writer, however great his experience, and however explicit his instructions, to give to the beginner a knowledge of the use of drugs—for example, to lay down rules for him when to use and when to withhold opium in cardiac disease—it is comparatively easy to describe technical methods, and to equip a man, whose practical experience is small, with a wealth of procedure. The articles, for example, upon the methods of giving baths in high fever, on the correction of scoliosis and other faulty attitudes by postural exercises, or on the education of stammerers, are in every way admirable.

We should have liked a fuller account of the education of patients with locomotor ataxy, and the methods by which they may be taught to regain some co-ordination. The disciplinary treatment of hysteria and neurasthenia is well described. In short, the book is peculiarly well adapted to instruct in just those points where hospital teaching and hospital practice is inclined to be inefficient. The description of operative procedures occupies too large a space.

The Opsonic Method of Treatment. By R. W. Allen, M.B., B.S., late Gull Student of Pathology, Guy's Hospital. (H. K. Lewis, 1907.) 5s.

The book is described as "A Short Compendium for General Practitioners, Students, and others," and its object is modestly stated in the preface as "an endeavour to collect such facts as might suffice to give a general idea of the subject." The matter is one of enormous importance, for the time has come when every medical man must have clear definite opinions upon the utility or otherwise of vaccine treatment in disease. In his introduction the author makes bolder claims. "The medicine of the future," he says, "is the medicine of vaccines and of sera. The Empiricism of the past will give way to methods based upon scientific knowledge, and the public will no longer look upon medicine with a sceptical eye and dose themselves with ineffective nostrums." But even Mr. Allen will admit that he is anticipating. As matters stand at present, we do not know that all cases to which the treatment is applicable—from nasal catarrh to general paralysis of the insane—benefit by such treatment. We do not know that many are not made worse.

The author has done his work of description admirably, and has stated the claims of the methods fairly and moderately, but we maintain that what is mainly wanted by "general practitioners, students, and others" alike, is authoritative teaching by those whose prognostic powers are equal to the task of truly estimating the effects, for good and ill, of treatment by vaccines.

The book is well and clearly written, and the author makes a clear case for the necessity of determining frequently and regularly the opsonic index. Although we do not hold with those who work the opsonic index to two decimal places, we regard its determination as the best guide for the second administration of vaccine. In some cases, as the author points out, *e.g.*, gonorrhœal infection, the clinical manifestations must *not* guide the administration of vaccine.

As a readable description of the methods employed, and as a statement of the extent of the applicability of the opsonic method of treatment, we can heartily recommend this book.

Tropical Diseases. By Sir Patrick Manson, M.D., LL.D. (Cassell & Co., Ltd.) 12s. 6d. net.

The rapid advance in knowledge of tropical diseases and their causation has necessitated a revised and enlarged edition of this work. In spite, however, of the

inevitable increase in size of the book, it still fulfils its purpose in being a handy volume both for students at home and for medical men in the tropics, and nothing has been added which is not of great value.

The advance in knowledge since the first edition was brought out in 1898 can be seen by comparing the two editions. The mosquito has been definitely established as an important factor in many diseases, and a very able chapter on the anatomy of this insect is given in the new edition. In addition to Malaria, it plays an important part in Yellow Fever and Filariasis, and is also suspected in Malta Fever, Dengue, and other diseases. Other new or revised articles in this edition describe the discovery of a trypanozome in man, and its relation to sleeping sickness; the discovery of an unsuspected route by which Ankylostomum Duodenale gets access to the human intestine; the discovery of the nature and germ of Kala Azar and Tropical Sore; the discovery of a new form of Relapsing Fever and of its transmission by ticks or bed-bugs; and the definite establishment of the rat flea as the communicator of Plague.

The chapter on Plague is one of the best in the book, and should be of great interest even to those who never expect to meet with a case. The possibility of this disease spreading from India to Europe in the near future makes Sir P. Manson's advice on prophylaxis very valuable. It is a pity that the chapter on Malta Fever does not record the wonderful results brought about by the more recent methods of treatment. Many authorities will fail to agree with the author when he says that the results after a single anti-typhoid inoculation are better than after two (p. 315). We believe we are right in saying that the immunity increases with each inoculation.

However, this may still be a debated point, and we can thoroughly recommend this volume to all those who have any wish to study that most fascinating branch of medicine—Tropical Diseases.

Preparations, etc., Received.

Ilford X-Ray Plates.

Ilford, Limited, have forwarded us a sample of their new Ilford X-Ray Plates, 12 in. by 10 in. They gave every satisfaction on trial, and are well up to the high standard for which this Photographic Supply Company is noted.

Formamint Tablets.

This is a preparation consisting of Formic aldehyde in combination with Lactose. It is an excellent oral disinfectant, combining all the advantages of the usual antisceptics used, with few of their disadvantages. It is non-poisonous, non-irritant, and its compact form makes it an excellent specific in all inflammatory conditions of the mouth and throat. The manufacturers are Messrs. Wulfung & Co., 83, Upper Thames Street.

In Lighter Vein.

Patience,

My past is pure and scarless,
I spent each vacant date
In reading Rose and Carless,
Or watching Willie plate.
And when I tired of reading,
I'd see some tragic play,
Which virtuous proceeding
Would close my modest day.

My commonplace correctness
Advanced me more and more;
My obvious selectness
Had made appointments sure.
Till—saddest of narrations!
A direful tale to tell!
I took to playing Patience,
And that is how I fell.

So now, in spite of joking,
I smother vain regrets,
And spend my day in smoking
The externs' cigarettes.
I feverishly bring up
Each column to my need;
And when I get a King up,
The World is bright indeed.

What though the spicy breezes
Blow soft o'er Java's isle,
What though at brilliant wheezes
I find no time to smile.
A week ago—ah, heaven!
The day was nearly won,
Had I not slipped a seven
I might have got it done.

Shun education's pressure,
Leave scientific doubt;
Learn Patience as a fresher,
And live to get it out!
Tho' friends and hopes desert you,
You'll find it rather nice;
For "Patience is a Virtue"
That grips you like a vice!

S. S.

From the Gazette's Special Pathologist.

G.E.H., RAMSGATE.—This growth is a carcinoma of the breast of the scirrhus type. It is infiltrating all the tissues of the breast, and spreading along the lymphatics.

PATHOLOGIST.

Notices.

British Medical Association.

GRANTS AND SCHOLARSHIPS FOR SCIENTIFIC RESEARCH.

GRANTS.

The Council of the British Medical Association desires to remind Members of the Profession engaged in Researches for the advancement of Medicine and the Allied Sciences that it is prepared to receive applications for grants in aid of such research.

Applications for sums to be granted should reach the office not later than May 15th, and must include details of the precise character and objects of the research which is proposed.

Every recipient is required to furnish to the Science Committee, on or before May 15th following upon the allotment of the grant, a report (or, if the object of the grant be not then attained, an interim report to be renewed at the same date in each subsequent year until a final report can be furnished) containing:

(*a*) A brief statement for the report of the Science Committee, showing the results arrived at, or the stage which the inquiry has reached.

(*b*) A general statement of the expenditure incurred, accompanied, so far as is possible, with vouchers.

(*c*) A reference to any Transactions, Journals, or other publications in which the results of the research have been printed.

The work of the Grantees shall be subject to inspection.

RESEARCH SCHOLARSHIPS.

The Council of the British Medical Association is prepared to receive applications for three Research Scholarships, each of the value of £150 per annum, enable for one year, and subject to renewal by the Council, provided the whole term of office shall not exceed three years.

The Scholarships exist for the encouragement of research in Anatomy, Physiology, Pathology, Bacteriology, State Medicine, Clinical Medicine, and Clinical Surgery.

The Scholars' work shall be subject to inspection.

ERNEST HART MEMORIAL SCHOLARSHIP.

The Council of the British Medical Association is also prepared to receive applications for the Ernest Hart Memorial Scholarship, of the value of £200 per annum, tenable for one year, but subject to renewal by the Council, provided the whole term of office shall not exceed three years. The Scholarship is for the study of some subject in the department of State Medicine.

Applications for Scholarships and Grants should, as a ule, be accompanied by a recommendation from the head of the laboratory in which the applicant proposes to work, setting out the fitness of the candidate to conduct such work, and the probable value of the work to be undertaken. This is not intended, however, to prevent applications for Grants in aid of work which need not be performed in a recognised laboratory.

Forms of application for Scholarships and Grants can be had on application to the General Secretary.

GUY ELLISTON,
General Secretary.

6, Catherine Street, Strand, W.C.
February, 1908.

Royal College of Surgeons.

Three lectures on the Surgery of the Spinal Cord and its Membranes will be delivered in the Theatre of the College on Monday, Wednesday, and Friday, February 24th, 26th, and 28th, at 5 o'clock, by Professor Donald Armour, F.R.C.S. (Hunterian Professor). The subheadings for each day, respectively, are Spina bifida, Fracture, Dislocation, and Tumours.

University of Cambridge.

The Third Examination in Medicine and Surgery (Part II.) will commence on Tuesday, April 28th. The names of intending candidates should reach the Registrary on or before Tuesday, April 14th. The M.C. Examination will commence on Thursday, April 30th.

Royal College of Physicians, 1908.

Lectures of the present year will be delivered at the College, Pall Mall East, on the following Tuesdays and Thursdays, at 5 o'clock:—

MILROY LECTURES.—Dr. J. W. H. Eyre, March 5, 10, 12. "Melitensis Septicæmia." ("Malta or Mediterranean Fever.")

GOULSTONIAN LECTURES. Dr. Herbert French, March 17, 19, 24. "The Influence of Pregnancy on certain Medical Diseases, and the Influence of certain Medical Diseases on Pregnancy."

LUMLEIAN LECTURES. — Sir James Sawyer, M.D., March 26, 31; April 2. "Points of Practice in Maladies of the Heart."

OLIVER-SHARPEY LECTURES.—Prof. E. A. Schäfer, F.R.S., April 7, 9. "The present position of our knowledge regarding the Supra-renal capsules."

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated.*

Sport.

Rugby Football.

GUY'S v. PLYMOUTH.

The first XV. suffered their first defeat this season at the hands of Plymouth, who defeated them, on a very heavy ground, by 11 points to 5. The game took place at Plymouth on Saturday last, and was of the scrambling order. Saunders scored our only try. Lee converted. During the first half Digby got crocked.

REMARKS.—The game was essentially a forwards' game, our forwards showing to advantage. The home team's two tries were largely due to faulty tackling on Stringer's part. Duke played a good game. The three-quarters, on the whole, played well. The halves took all available advantages, whilst the forwards played with their usual dash.

GUY'S v. CAMBRIDGE.

This game took place on Wednesday, at Cambridge. Our team was considerably weakened by the absence of Moberley, Digby, and Archer, whilst J. P. Jones was suffering from an injury to his knee, incurred at Plymouth. After a fast game the home team were left victors by 10 points to 3, Lee kicking a penalty goal.

SECOND XV.

This team has had a successful year, and Captain Bennett is to be congratulated on the fact that his team have reached the Semi-final of the Surrey County Cup. In the first round they beat Mitcham by 16—0. To-day they meet Streatham. It will be interesting to note the issue of this match, the first XV. having defeated Streatham by 13 points.

Association Football.

GUY'S v. BART.'S.

INTER-HOSPITAL CUP TIE — 2ND ROUND.

The second round of the Inter-Hospital Cup Tie, which for us had resulted in being drawn against Bart.'s, was played on Wednesday, February 12th, at Winchmore Hill, on opponents' ground. The game commenced somewhat slowly, but after about ten minutes Birks and Whiteley did some very pretty cross-passing, enabling them to escape the backs and leaving Whiteley with an open goal into which he put the ball.

No more scoring was done until after half-time, when Bart.'s, from a corner, managed to put in a slow shot from a crowd in the front of the goal mouth. Immediately, however, on restarting, Guy's made a rush, and Birks scored for the Hospital.

Bart.'s became somewhat reckless, playing with great fury, and five minutes before the end the left outside, having put in a very brilliant shot, scored. This left the score as 2—2, and it terminated as this when the whistle blew.

The replayed Cup Tie against Bart.'s resulted in a victory for our first XI. by 6 goals to 1.

Change of Address.

Dr. E. C. Bevers, from 71, S. Giles', Oxford, to 42, Broad Street, Oxford.

Fleet Surgeon Robley H. J. Browne, R.N., from H.M.S. *Majestic*, Home Fleet, to H.M.S. *Venerable*, Channel Fleet.

Dr. W. A. Carden, from Frazerburg, Cape Colony, to Bothaville, Orange River Colony, South Africa.

Dr. H. Hunter Carter, from Beech House, Wingate, Co. Durham, to Derbyshire Royal Infirmary, Derby.

Dr. Maurice Craig, from Bethlem Royal Hospital, to 54, Welbeck Street, W.

Dr. J. E. Collins, from 149, Walworth Road, S.E., to St. Ronans, Barking Road, East Ham, E.

Dr. C. E. M. Jones, from Guy's Hospital to Rawdon House, Alton, Hants.

Dr. Percy A. Peall, from Goodmayes, Essex, to Eldorado, Lomagunda, Southern Rhodesia, South Africa.

Dr. H. Douglas Smart, from 3, St. Mark's Place, Dewsbury, to Shelley, near Huddersfield.

Dr. C. M. Stevenson, from Hollymoor Asylum, Northfield, near Birmingham, to Arnold, Notts.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Birth.

MORGAN.—On February 6th, at Groombridge, Sketty, R.S.O., Glamorganshire, the wife of Edward Morgan, M.R.C.S. Eng., L.R.C.P. Lond., of a son—"Edward Guy."

Marriage.

ZORAB—PARSONS.—On Feb. 1st, at Christ Church, Blacklands, Hastings, by the Rev. Canon Alfred Hodges, assisted by the Rev. J. F. Kendall, of St. Germans, Blackheath, S.E., Arthur Batoum Zorab, Indian Medical Service, son of the late Lieutenant-Colonel J. M. Zorab, I.M.S., to Olive, youngest daughter of Mrs. F. J. Parsons, of Cumberland House, Laton Road, Hastings.

Deaths.

AIKIN.—On February 11th, at Llandrillo, Merionethshire, Charles Arthur Aikin, F.R.C.S., formerly of Clifton Place, Hyde Park, aged 87.

GALTON.—On February 7th, at Chunam, Sylvan Road, Upper Norwood, John Henry Galton, M.D. Lond.

MAISEY.—On February 10th, at Falmouth, Frederick Thomas Maisey, M.R.C.S., L.S.A.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXII., No. 514.] MARCH 7, 1908. [SIXPENCE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

March.

Sat. 7. 2nd XV. v. U.C.S. Old Boys (Away).
1st XI. v. Ramsgate (Away).
2nd XI. v. Sevenoaks School (Away).
Pupils' Physical Society, Clinical Evening, at 8 p.m. Mr. Goodhart in the Chair.

Mon. 9. Special Clinical Lecture by Mr. Ormond, at 1.15 p.m.
April Appointment List closes.
Meeting of Dental Society at 4.30 p.m.

Wed. 11. Examinations for General Proficiency, Michael Harris and Woolridge Memorial Prizes begin.
Debating Society's Annual Dinner at 7 p.m.

Thur. 12. Exam. for Golding-Bird Medal in Bacteriology begins.
Mr. Lane's Take-in commences (Mr. Walker).
Final Cup Tie v. London at Richmond.

Fri. 13. School Exam. in Experimental Physiology.

Sat. 14. 1st XI. v. Simmaries (Away).
2nd XI. v. Sidcup "A" (Away).
Debating Society's Meeting at 8 p.m.

Tues. 17. Exams. for Dental Prizes commence.

Wed. 18. Display of Boxing, Fencing, etc., in Physiology Theatre, at 7.30 p.m.

Thur. 19. Mr. Dunn's Take-in commences. (Mr. Smalley.)

Fri. 20. Meeting of Physical Society at 8 p.m.
School Exam. in Anatomy.

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Passim.

THE much-delayed Souvenir of the Residents' Theatricals has at last made its appearance, and we trust that it amply fulfils all the predictions which from time to time have appeared in the columns of the GAZETTE. Judging from the remarks which one hears on all sides, Messrs. Brookhouse, Chapple and Wingent should feel highly pleased with their effort. No little credit is due to Messrs. Ash & Co. for the artistic and finished manner in which they have turned out this production, the letterpress and binding being in every way admirable. It should be borne in mind that the profits which accrue from the sale of the Souvenir are to be devoted to the hospital funds; therefore, ye tardy subscribers, hasten, before the edition is sold out. Not many extra copies have been printed, and we have no doubt that the demand will be greater than the supply. Copies may be obtained from the Librarian, Miss Smith (Matron's Office), or at the Porter's Lodge, College. Any of our readers unable to obtain copies by personal application to the above, can obtain them by writing direct to the Editor of the GAZETTE. We can guarantee a good half-crown's worth, and as a souvenir for men at present amongst us we know no better investment.

A FAMILIAR face has been missed from the Front Lodge, during the last three weeks, caused by the resignation of Mr. Prestage, the head porter. Continued ill-health has been the cause

of his leaving us, and we trust that he will soon be much better. For some twenty years he has filled his difficult and responsible position, and by his tact and consideration has held his own with the truculent and unmannerly folk who, on occasions, are to be seen at the Lodge. His civility and attention to his duties have always been striking features to those about the place, and his presence will be much missed.

It has been proposed that a little presentation should be made to him by those with whom he has been associated for a long time; anyone desirous of helping in this matter should apply at the Counting House.

In the February number of the *Zoophilist*, the official organ of the National Anti-Vivisection Society, appears a short article by the Hon. Stephen Coleridge, entitled "Battersea Students and the Battersea Monument," in which he cautions the fanatical section, or, as he terms them, "enthusiastic advocates '*totius porci*,'" against a too general abuse of medical students as a body. He trusts he will not be held up to obloquy by these neurotic enthusiasts of the cause, if he does not join in the application of such abusive epithets as "Mohawks," "Yahoos," or "Molochs," to a body of young men who, irrespective of any logical reason, delight to display an inordinate desire to have removed a certain statue. He states it is merely an outlet for youthful effervescence, and that the pure delight of "ragging," is the inspiration. He begs these ardent followers of his, to excuse them on the score of their age; for have they not all been young?

The whole article is exceedingly diverting, primarily since it is written in a strain which is so charmingly condescending, and, again, since the author has adopted a style of "been one of the Boys myself, you know," telling of what he might have done *after dinner* at Cambridge, when he was an undergrad. The whole publication is such a terrific, illogical tirade that, if the anti-vivisectionists wish to win over to their cause any of those students who "regard the guardianship we are endeavouring to throw over vivisected animals, with sympathy," they will have to modify their methods to a great extent.

Any of our readers who wish to read a summary and sane consideration of some of the evidence before the Royal Commission on Vivisection will find an admirable account in the February number of our esteemed contemporary, the *London Hospital Gazette*.

Many congratulations to the first XV. on their winning their way into the Final Cup Tie. The replayed tie against Bart.'s was one of the most exciting we have witnessed, it being in the last ten minutes, only, that our men snatched the game out of the fire. Our forwards met their equals in the St. Bartholomew pack, and it was only their superior condition which, in the end, told. Our backs played well, one and all, Jones unfortunately being handicapped by the injury which he received to his knee in the Plymouth match. By beating St. Mary's yesterday by 4 tries to nil, our team qualified to meet our old rivals, London, in the Final, on Thursday next.

Bravo, also, the 1st XI.! who, in a game which, at any rate up to half-time, was closely contested, beat St. Thomas's in the Semi-Final of the Inter-Hospital Cup. They now have to meet University College in the Final; this XI. has shown good form this year, and the match should be productive of much interesting play. It is pleasant to have to record such a series of victories for our teams, and we must not forget, in passing, to congratulate the Hockey XI., who, by beating Bart.'s last Monday, have captured the "mysterious" Inter-Hospital Hockey Trophy. What will next week bring us?

On Wednesday evening, March 18th, at 7.30 p.m., there will be held, in the Physiology Theatre, a grand assault-at-arms. The programme is an attractive one, consisting of boxing, fencing with foils, sabres and epées de combat, wrestling, gymnastics, etc. The performers include Corporal-Major Eggleton, who will again perform the sword feats which he exhibited last year; Sergt. Mumford, who will

give an exhibition of lance exercises, etc., on the slack wire; members of the City of London Police, who will give a display of wrestling; Instructors of M. Graves' School of Arms; members of the "Artists" Volunteers; and many of our own men. Tickets, 4/–, 2/6, 2/– (gallery front row) and 1/–, may be obtained at the Bar or on application to Mr. Oram, the Hon. Sec. The proceeds are to be divided between the Nurses' Cottage at Honor Oak and the Gymnasium. It is hoped that this performance will receive all the patronage that is its due.

On Friday evening, March 20th, at 8 p.m., we would remind our readers, will take place the final meeting of the Pupils' Physical Society. Dr. Frederick Taylor has kindly consented to take the chair, and the Treasurer's Prize Essay on the Diagnosis of Acute Abdominal Conditions is to be read. We trust there will be a good muster of men to meet our popular ex-senior physician.

The Annual Dinner of the Debating Society is to be held on Wednesday next, March 11th, at 7 p.m., in the College Dining Hall. Dr. Savage is to be in the chair, and has promised to give a short address on "Dreams." Tickets, price 3s. each, may be had on application to the Hon. Secs., Messrs. D. Reynolds and A. Neville Cox.

On another page will be found a letter from an esteemed correspondent, who desires to remain anonymous, anent the Regulation relating to the acceptance of fees from private individuals by members of the Indian Medical Service. We quite agree with him that some check should be placed upon those who are not over-scrupulous in their dealings; they are, fortunately, few and far between, and it seems hard that the whole service should have to suffer a slur upon its integrity and a severe shock to its dignity for the sake of a few miscreants.

We have received notice of the International Congress on Tuberculosis, which is to be held, this year, in Washington, from September 21st to October 12th. In connection with the Congress, a prize of $1,500,000 is offered for the best treatise "On the Relation of Atmospheric Air to Tuberculosis." Further details may be had on applying to the Secretary-General, 714, Colorado Buildings, Washington, D.C.

The encouragement which is given to original research in America is well exemplified by the announcements of scholarships and fellowships which are awarded annually by the Rockefeller Institute of New York. These scholarships range from £175 to £250, and are open to all medicos, the possession of a degree not being essential. All details may be obtained by writing to the Secretary, 14, West 55th Street, New York City.

Guy's men should bear in mind the following dates of lectures to be delivered by members of our Staff at the College of Physicians. Milroy Lectures, Dr. Eyre, March 5th, 10th, 12th; Goulstonian Lectures, Dr. French, March 17th, 19th, 24th; whilst on March 9th and 11th, Mr. Ralph Thomson (Hunterian Professor) will lecture at the Royal College of Surgeons. These lectures commence at 5 p.m.

Mr. Finnemore's complete Report for 1907 of the work done by the Pharmaceutical Laboratory, and the amount of drugs, etc., dispensed, is interesting as an addendum to the official office report published in the last number. It would give great scope to any budding statistician to tell us, for example, how far around the world the bandages used during the year would reach if put end to end. Mind you, we don't invite it, for personally we hate the "Tit-Bits" type of pill-box statistics. Nevertheless, as we have said, it would give great scope.

One item in the above Report which caught our notice was the increase in the number of non-paying out-patients patronising this department. Doubtlessly this is a reflection of the depression which has been so general this year.

There are rumours of a smoking concert in the air. Nothing is definitely settled yet, but the probable date may be the 21st March. Those who remember the "smokers"

in the olden days will welcome this news with pleasure, and for those who have not yet attended a Guy's smoker, we can promise a real good evening's enjoyment. The incompleted list of talent, vocal and otherwise, is very promising. So be on the look-out for posters giving full details, and you, lucky men, who are off for your April vacation, defer your departure, and join the merry throng.

Nursing News.

Matron's Office.

On January 25th, Nurse Baber, Head Nurse in Lazarus, left on completion of her three years' training, and Probationer Gill was appointed to succeed her as Head Nurse.

On January 27th, Nurse Finnis, Head Nurse in Astley Cooper, left the Hospital on completion of her training, to take up her duties on the Private Nurses' Staff. Nurse Sayer, Head Nurse in Victoria Ward, was transferred to Astley Cooper as Head Nurse.

On February 15th, Nurse Briggs, Head Nurse in Cornelius, left the Hospital on completion of her training. Nurse Binder, Head Nurse in Ruth Ward, was transferred to Cornelius, and Probationer Evans was appointed Head Nurse in the Eye Wards.

On February 19th, Nurse Garside, Staff Nurse in the Surgery, left the Hospital. Nurse B. Martin, Head Nurse in Stephen Ward, was appointed to succeed her as Staff Nurse, and Probationer Ball was appointed Head Nurse in Stephen Ward.

On February 24th, Nurse Farrow, Head Nurse in Mary Ward, was transferred to the Electrical and Light Department, and Probationer A. M. Phillips was appointed Head Nurse in Mary.

On February 27th, Probationer Clifton was appointed Head Nurse in Bright Ward.

We much regret to announce the death of Nurse Hilda Mary Ingleby. On Monday, February 22nd, she contracted scarlet fever, and was sent to the South Eastern Fever Hospital, where she rapidly became worse, and died mid-day on Saturday, the 29th. Nurse Ingleby commenced her training as Probationer in January, 1906, and only the week previous to her death was appointed Head Nurse in Bright Ward. The funeral took place at Hull on Tuesday, a memorial service being held in the Hospital Chapel that morning, A large cross, composed of white stock, Harrissii lilies, lilies of the valley, and other flowers, was sent by members of the Nursing Staff, as well as other wreaths by individual members.

Change of Address.

Lieutenant F. A. Barker, M.B., B.C., Indian Medical Service, from Guy's Hospital, to care of Messrs. King, King & Co., Bombay.

Mr. Harold Chapman, L.D.S., from 115, Harley Street, W., to 20, Queen Anne Street, Cavendish Square, W.

Dr. T. A. Matthews, from 26, Victoria Road North, Southsea, to 6, The Green, Richmond, Surrey.

Mr. J. E. Spiller, L.D.S., from Newton Ferrars, 128, Worple Road, Wimbledon, S.W., to Tressillian, 62, Worple Road, Wimbledon, S.W.

Dr. S. M. Wells, from 52, Holland Road, Kensington, W., to c/o Armstrong, Borrowman & Co., Valparaiso, Chile.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

From the Gazette's Special Pathologist.

T. L. J., Cheadle.—Although this specimen arrived flattened out and somewhat dry, its characters on section are such as to exclude malignancy. It appears to be a simple papilloma.

S. W., Middlesbrough. — No tubercle bacilli are detected in this specimen of sputum, which contains but little muco-pus. (Mrs. W.)

S. W., Middlesbrough.—Tubercle bacilli are present in moderate numbers in this specimen. (Miss W.)

B., Mitcham.—*Reaction*, acid: *sp. gr.*, 1012: *Albumen*, a considerable amount; *blood*, vide infra; *sugar* absent. *Microscopical examination of the centrifugalised deposit*: The deposit consists of an immense amount of greenish pus, considerable numbers of small granular cells are present, and a few red blood discs are observed here and there. Bacteria are fairly numerous; they are practically all small motile rods which might well be colon bacilli. No tube casts have been found, and no crystals are present. This immense deposit of greenish pus is generally characteristic of pyonephrosis or sometimes of kidney abscess, although in the latter case there is often more blood. No special examination for tubercle bacilli or other organisms has been made, as it is uncertain whether you require it.

W. L. W. M., Huddersfield.— This specimen of sputum contains a moderate number of tubercle bacilli.

Pathologist.

Dispensary and Pharmaceutical Laboratory Report for 1907.

The total number of dispensary attendances by Out-patients during 1907 was 204,869, as compared with 206,443 in 1906, and 189,974 in 1905. They are divided into patients who pay 3d. each week for medicines, etc., and those who, being too poor, receive their treatment free. The following table gives the details for the last two years:—

1906	Medical.	Surgical.	Casual.	Total.	Total.
Paying	74,403	33,075	64,968	172,451	206,443
Free	—	—	—	33,992	
1907					
Paying	75,686	25,946	60,914	163,546	204,869
Free	7,718	3,561	30,044	41,323	
	84,404	29,507	90,958	a decrease of	1,574

It will be noted that the attendances by Out-patients who receive their medicines free has increased by 7,331 in 1907. In 1904 the proportion was 121 per 1,000; in 1905, 148 per 1,000; in 1906, 147 per 1,000; and in 1907, 201 per 1,000 attendances. Taking casual cases alone, the proportion in 1907 was 330 per 1,000 attendances.

The table below, showing a decrease of £130 18s. 7d., gives the amount of money received in the last two years:—

	1907. £ s. d.	1906. £ s. d.
Out-patients	2,040 4 6	2,170 12 1
Sale of drugs	97 16 0	117 12 3
Net profit on sale of bottles to Out-patients	94 13 11	84 5 3
Goods supplied to the Medical School	69 8 5	58 7 11
Goods supplied to the Dental School	44 14 0	36 16 11
Goods supplied to the Institution	30 16 5	40 17 5
	£2,377 13 3	2,508 11 10

There is a decrease of £130 7s. 7d. in the receipts from Out-patients, representing the increase of 7,331, due principally to the increase in the attendances above mentioned.

The total cost of drugs and dressings during 1906 and 1907 is given below from figures supplied by the Clerk to the Governors.

	1907. £ s. d.	1906. £ s. d.
Drugs	2,567 10 1	2,427 0 0
Dressings ...	2,592 2 4	2,760 0 0
	£5,159 12 5	£5,187 0 0

Decrease in 1907, £28.

ANÆSTHETICS.	1907. Quantity used.	1906. Quantity used.	1907. Cost. £ s. d.	1906. Cost. £ s. d.
Alcohol absolute	272 lbs.	194 lbs.	41 19 3	30 3 0
Chloroform	881 lbs.	782 lbs.	58 14 1	49 1 2
Cocaine	26 ozs.	12 ozs.	11 19 6	6 15 0
Ether	674 lbs.	575 lbs.	65 18 5	55 11 2
Ethyl chloride	138 tubes	350 tubes	10 10 10	26 17 9
Nitrous oxide	6000 galls.	3600 galls.	10 10 0	6 5 0
			£199 12 1	174 13 1

The increase in cost as compared with 1906 is £25.

It will be of interest, in connection with the above list, to state that, prompted by the remarks made at an inquest with reference to a death under an anæsthetic, enquiries were made as to the preparation of the chloroform and ether used in the large London hospitals.

There are three sources available for the manufacture of chloroform, viz.:—rectified or duty-paid spirit, industrial spirit, and acetone. Six of the large London hospitals use chloroform derived from acetone, two from industrial spirit, and one from rectified spirit. All hospitals employ ether manufactured from industrial spirit.

ANTISEPTICS.	1907. Quantity used.	1906. Quantity used.	1907. Cost. £ s. d.	1906. Cost. £ s. d.
Acid Boric	26 cwt.	25 cwt.	32 2 0	30 10 8
Acid Carbolic	30 cwt.	33 cwt.	87 10 0	100 2 0
Chinosol	8 lbs.	4 lbs.	4 9 0	2 8 0
Cresol	120 galls.	120 galls.	8 4 0	6 2 6
Formaldehyde	672 lbs.	644 lbs.	11 10 6	13 4 9
Hydrogen Peroxide	180 galls.	84 galls.	21 2 10	11 18 4
Iodoform	28 lbs.	42 lbs.	16 4 4	28 15 2
Lysol	575 galls.	600 galls.	108 12 8	128 4 4
Mercuric Chloride	85 lbs.	66 lbs	8 5 10	6 15 7
			£298 1 2	328 1 4

The decrease in cost, as compared with 1906, is £30, in which year the cost was £40 less than in 1905.

DRESSINGS.	1907. Quantity used.	1906. Quantity used.	1907. Cost. £ s. d.	1906. Cost. £ s. d.
Bandages, Grey	906 gross	982 gross	448 16 0	462 13 6
Bandages, White	665 gross	636 gross	463 12 9	421 16 2
Bandage Cloth	9,774 yards	12,770 yards	69 7 10	75 18 4
Cellulose Wadding	252 lbs.	1½ cwt.	4 16 10	3 13 6
Felt	24 sheets	None bought	6 0 10	—
Felt, Poroplastic	4 lbs.	—	0 18 0	5 15 0
Gauze, Double Cyanide	28,092 yards	23,000 yards	98 4 9	72 18 5
Gauze, Grey	38,760 yards	35,000 yards	95 5 6	87 15 3
Gauze, Iodoform	15,108 yards	20,000 yards	71 10 3	91 19 4
Gauze, Ribbon	21 doz.	—	7 2 6	6 0 0
Holland, Brown	20 rolls	21 rolls	48 2 2	40 2 4
Lint	97 cwt.	99 cwt.	514 13 3	481 4 1
Lint, Boric	16 cwt.	20 cwt.	68 1 2	84 16 4
Moss, Compressed	440 sheets	252 sheets	11 0 0	10 19 6
Mead's strapping	—	—	9 8 8	7 14 8
Tissue, Gamgee	2½ cwt.	2½ cwt.	11 1 8	10 15 10
Tissue, Gutta Percha	435 lbs.	416 lbs.	76 5 2	73 5 11
Tow	13 cwt.	20 cwt.	13 6 0	19 11 0
Wool, Absorbent	101 cwt.	102 cwt.	285 16 10	299 12 7
Wool, Grey	30 cwt.	30 cwt.	56 4 0	57 14 0
Wool, Sal Alembroth	10 cwt.	7 cwt.	37 7 4	30 3 2
Wool, Salicylic	2 cwt.	6 cwt.	8 8 0	25 13 4
			£2,405 9 6	£2,370 2 3

Increase of £35 in 1907.

Pharmaceutical Laboratory.

The work of this section has been as follows :—

	1907.	1906.
Collodions ...	10 galls.	11 galls.
Confections ...	2 cwt.	3 cwt.
Dentifrice ...	160 lbs.	136 lbs.
Lotions ...	4,680 galls.	4,600 galls.
Ointments ...	40 cwt.	46 cwt.
Pills and Tablets	342 lbs.	450,000 or 2½ cwt.
Plasters ...	5,900 yards.	7,500 yards.
Liniments ...	254 galls.	317 galls.
Powders ...	7 cwt.	10 cwt.
Mixtures ...	8,620 galls.	10,640 galls.
Syrups ...	700 galls.	1,080 galls.
Tinctures ...	200 galls.	250 galls.
Soda Water ...	26,850 syphons	40,000 syphons.

January 22nd, 1908.

Dental News.

The Annual Dinner of the Dental Society was held at the Trocadero on Saturday, February 23rd, the President, Mr. F. J. Pearce, occupying the chair.

The usual loyal toasts having been drunk, Mr. Maggs, who was received with great applause, in a felicitous speech proposed "Guy's Hospital and its Schools." He referred to the great growth of the latter, especially as regards the Dental School, the unrivalled success of this institution being, to no little extent, due to its association with the Medical School. It was with regret —which was amongst Guy's men, past and present, quite universal—that he had to announce the retirement of Mr. Newland-Pedley from the active Staff, but one and all, he was sure, would be pleased to hear that the Governors had appointed him Consulting Dental Surgeon.

Dr. Hale White briefly replied for the Hospital, referring to its traditions and the great part it played, at present, in the Metropolis as a centre of healing.

Mr. Eason, replying for the Schools, said that he was almost in despair in having to reply to this toast. In the first place it was a very difficult matter to come after Dr. Hale White in any speech, and in the second place he had had to reply to the same toast for five years in succession. He always looked forward, however, to the opportunity of speaking to them, and, although he met some of them in another capacity during the year, on this occasion he could, like Balaam, come to bless and not to curse. The success of the Dental School could be estimated from the fact that at the last examination for the L.D.S., one-third of the whole pass list for the United Kingdom consisted of the names of Guy's men. Except for the loss of Mr. Newland-Pedley's services, the Dental School had in the past year been in the happy position of a nation that had no history; but he might mention that the success of the mechanical laboratory for dental pupils had been great, for it was only opened in October last, and was now crowded to the utmost limit of its capacity, and that new accommodation would have to be made before the commencement of another session.

He was also glad to be able to announce that, owing to a donation of £10,000 from an anonymous benefactor, and a grant of an equal amount from the King Edward's Hospital Fund, a new Out-patient Department was shortly to be built, in which there would be separate accommodation for the Dental Out-patient Department. Happily, therefore, in the future, the Dental Staff and students would not have to work in a room utterly unsuited for the purpose, nor would he be compelled to sit in the same place for Ophthalmic Out-patients with people crunching all over the floor on the molars extracted in the morning.

It was also a great pleasure to have an annual occasion of saying something to them about the general aspects of the dental profession, and he wanted to say a few words this evening as to their position with reference to the public. He would remind them at the outset that they could never hope that the public would ever accept their trades' union, as they could see that the unregistered dentist would never be put down any more, than in the medical profession the sale of quack medicines, would ever be prevented; he was often asked the question as to what the benefit of the L.D.S. diploma was. The L.D.S. was bound by rules and regulations which did not apply to the unregistered practitioner. He could not advertise, nor put his photograph in the local press. He could not have an attractive show case of teeth in the front garden, nor could he take advantage of many of the other ways of attracting public attention; and it was very hard, therefore, on the more respectable members of the profession, to see their unregistered and unqualified competitors making as great or greater incomes than their own. That might all be very true; but he would remind them that a gentleman could not do things that a costermonger could, and just as he had advantages so he had limitations; and that the great duty of every member of the dental profession was by continual example to educate the public to realise that the title of L.D.S. meant the assurance that the holder of it would do the best work and the most honest work, and most faithfully serve the interests of his client.

The toast of "The Dental Society" was proposed by Mr. Lane, who said: "Gentlemen,—It is with much pleasure that I rise to propose the toast of the Dental Society. It is such a singularly flourishing and successful institution that it is necessary for me to say only a few words about it. Its very rapid growth illustrates in a marked manner the rapid progress of events in the last few years, and we have every reason to believe that the future career of this Society will be even more brilliant than the past. I ask you to drink to the increased prosperity of the Dental Society, coupling with the toast the name of your distinguished president.

The President, in his reply, referred to the wide range of subjects shown in the papers read before the Society, and also to the opportunities afforded of learning by the ensuing discussions.

Mr. LEWIN PAYNE proposed the Visitors, coupling with the toast the name of Mr. Underwood.

In replying, Mr. UNDERWOOD said: Mr. Chairman and Gentlemen,—Speaking in the names of my fellow guests and myself, I am convinced of the genuineness of our welcome. Your Dean asks, Is the L.D.S. any good? The practitioner here in London, when he has a patient removing to a country district, looks up the British Dental Association's list of men in provincial towns and sends the patient to one of these; but the great side of the question is that of upholding the flag and honouring the traditions of Guy's.

In the course of a happy speech, in which he proposed the health of the Chairman, Mr. SPILLER referred to the personal popularity and the hard work accomplished by our Preaident.

The toast was received with enthusiasm, and Mr. PEARCE in replying, said, Gentlemen, I thank you for the more than kind manner in which you have received this toast. I feel very conscious of not having fulfilled my duties in the able manner which my distinguished predecessors have led you to expect, but I yield to no man in my interest in Guy's Dental School, and all that appertains to it. Gentlemen, I believe that the profession to which we belong has a great future before it, and that it will hold a far more honourable and important position than the public at present accord it. I thank Mr. Spiller for the kind manner in which he has proposed this toast, and you for the kind manner in which you have received it.

The Secretary's health was then drunk to, and a very enjoyable evening terminated.

During the evening vocal and elocutionary numbers, which were very much enjoyed, were contributed by Messrs. Spain, Gibbings, Rutter, Humm, Tait, and Clifford.

Appointments.

Civil.

CROFTS, Mr. A. DOUGLAS, has been appointed by the Town Council of Windsor Medical Inspector of School Children under the new Education Act.

FORTESCUE-BRICKDALE, JOHN M., M.D., B.Ch. Oxon., has been appointed Director of the Public Health Laboratory, University College, Bristol.

GLENN, C. H., M.B., B.C. Cantab., has been appointed District Medical Officer of the Cuckfield Union.

LOUISSON, M. G., M.B., B.S. Lond., has been appointed a Public Vaccinator for the District of Christchurch, New Zealand.

PHILLIPS, J. G., M.B., B.S. Lond., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Assistant Physician to Bethlem and Bridewell Royal Hospitals and Assistant Medical Officer to King Edward Schools, London and Whitley.

SIMPSON, GRAHAM S., F.R.C.S. Eng., has been appointed Clinical Tutor in Surgery, University of Sheffield.

Life in the I.M.S.

BY CAPTAIN WATTS.

Christmas in Camp.

As in the course of my wanderings in the district I had heard of a good place for shikar,[1] I wrote and asked R. to come down for a Christmas shoot and a talk over old times. So the evening of December 22nd saw me welcoming R. at the railway station after a journey of over twenty-four hours from the little frontier cantonment where he is stationed. We had to wait a few hours before getting our train on, so we adjourned to the refreshment room for dinner. There, as so often happens in India, we met a canal man who was at school with us both many years ago. A couple of hours in the train brought us to the rest house, from which we were to start on the morrow, R. having rendered himself unpopular with the railway staff by chasing the head lamp cleaner round the station with a cane for having refused to help get our luggage out. Next morning, after a substantial meal, we tackled the always difficult task of portioning out loads to coolies, our and their ideas of what constitutes a load differing considerably; witness the sturdy individual trudging off with an empty kerosine oil tin as his share of the baggage. Some twenty coolies went on ahead yesterday with the tents, stores, and Khansamah, whilst we took the rest of the servants and about as many more coolies with us. At eleven we are off with our faces to the hills and our backs to the level monotonous plains, full of energy, hope and breakfast.

Our way leads first up a broad stony river bed, which in the rains is swept by a roaring torrent, but is now dry except for a few streams of clear cold water; on our left towers a mountain range, bare, except for a few pines scattered along its crest; whilst on the right low hills thickly covered with scrub shut in the view. Five or six miles on and the scenery becomes more picturesque, the river bed narrows, and we have to pick our way between huge boulders, fording repeatedly the tiny river. Tall palms and luxuriant foliage give an oriental aspect to the scene that one does not meet with as a rule in the Punjab, whilst the occasional sight of quail, partridge, pheasant or jungle fowl cheers our hearts. The track was very bad, and evidently not much used, the only frequenters of it being the inhabitants of the few thatched huts we passed, or people taking their maize to be ground into flour at the "panchakkies," a primitive kind of water-mill to be met with on nearly every hill stream where there is a sufficient fall of water.

We had now been going some four hours, and what with the hot sun, the bad stony path, and our unaccustomed exercise, we had lost our first freshness. Enquiries as to the distance we had yet to go were, however, futile, as few of the natives seemed to know anything about the

1 Sport.

place, and a man would tell you it was twelve miles, while two miles back, you had been told it was ten. At last we commenced to climb out of the nullah along the hills on our right—and it was a climb! Before we reached the top we had to halt and admire the view from the roof of a snug little house perched on the hill-side, and welcome indeed was the hot milk the inhabitants hospitably provided for us. Our hill-side was now in shadow, and the chill after resting for a short time warned us we must be getting along: so with a last four miles to the old fort, where we hoped to find our camp, we trudged bravely along, and when at length we reached the top of the hill heaved a sigh of relief. We sent one of the servants to search for our camp, and you can imagine our horror when he returned with the news that our coolies had reached there the previous night, but in the morning had gone on five miles down the hill on the other side, as they found supplies here were difficult to obtain.

It was now six o'clock, and nearly dark. We were all footsore, dog tired and hungry, with the pleasing reflection that our baggage was miles behind, and even if we got our dinner, there would be no bed or bedding for us. However, necessity knows no law, so after sharing the last drops of water in R.'s treasured "Thermos" flask, we hobbled off down the hill. Oh, that last five miles! Pitch dark and no road—simply a track covered with loose rolling stones, from the size of a football downwards. How we stumbled about and ricked our ankles! What a hunger we had, and how we blessed our guide when several times he lost his way, and we were brought to a stop by dense jungle! However, everything has an end (as I used to console myself at Pathology lectures), and at last we saw below us the lights of our camp, reflected in a small lake beside it. A stiff brandy peg, and then we tackled the meal the Khansamah had provided for us by the side of a roaring fire, and our appetites were pretty sharp after covering some twenty miles or more—a long march in the hills. After a pipe, we stretched ourselves before the fire, and though we had to sleep wrapped in odd pieces of canvas and matting, consoled ourselves with the reflection that we might have been worse off. R. got so close to the fire that several times, when I woke, I had to prod him and make him move, for fear his manly figure might be irretrievably damaged by fire. We woke stiff and sore, and it was not till the rest of our kit turned up, and we had had a hot bath, that we felt ourselves again. The next business was to consult our shikari,[2] one Hukmi—an old man, some of whose "chits" were dated over thirty years ago.

A stroll round the edge of the jungle near at hand, brought us back to dinner with our larder well stocked for several days to come, in the shape of partridge and jungle fowl, R. thinking I was pulling his leg, when I told him that the fowls crowing in the jungles were the birds we had come to shoot. Christmas day we went out, taking our tiffin with us. The hill-sides here are broken up into innumerable nullahs, with precipitous banks thickly clothed with jungle and scrub, so dense in places as to be practically impenetrable, whilst at the bottom runs a trickle of water amongst the rocks and boulders, which bear witness that after rain they are scoured by a formidable torrent. The leaves had begun to change colour, and the foliage showed a variety of red and russet tints, that to eyes accustomed to the dull monotonous scenery of the plains, was very pleasant and seasonable. The aged Hukmi gives directions to the coolies, who set off to their places, whilst he stations R. and myself in our respective positions. Beating these jungles is always exciting, as one never knows what will come out, and No. 6, though excellent for partridge or quail, only tickles a sambhur, and might irritate a cross-grained beast, such as a panther, who is apt to show his resentment in an unmistakeable form. The cries of the beaters come nearer and nearer as they climb along the side of the hill, shouting, beating the bushes with their sticks, and rolling down large stones, that bound through the dense undergrowth into the stream below. To-day, R. gets the first shot, a karker, or barking-deer, one of whom we had heard barking in the jungle near our camp last night—a pretty little creature of a bright brown colour, and about the size of a small goat. They are very common about here, and we saw a good many. Up, with a great bustle and flutter, gets a peacock, who sails away past me, unruffled by the two shots I salute him with; however, I soon retrieve my character, bringing down a black partridge as he whirrs towards me. For a minute or two there is a rapid fusillade, as the jungle fowl and partridge, who have been lurking at the edge of the jungle, are forced to break into the open. So the day goes on with varying fortune, our modest tiffin disposed of near a spring, whilst Hukmi and the coolies squat round the "hubble bubble," which passes from one to the other in turn. It is getting dark as we slowly climb back up the hill towards camp, where the blazing fires and Jim's noisy bark give us a cheerful welcome. Hot baths, pyjamas and overcoats, and then we meet again in the little tent which serves as our dining room, rendered warm and cosy by a stove in the corner, for a height of even three thousand feet is cold at this time of the year.

We toast Guy's with our first glass of Beaune, and after a good dinner of teal, jungle fowl, and plum pudding blazing with brandy, a toast to absent friends again takes our thoughts back to Guy's, especially R.'s, who in his time was a notorious browser. Pleasantly tired we sit till late, until the tent is blue and hazy with smoke, recalling incidents in our careers at Guy's, early days in the dissecting room, and irresponsible rags up West, a time pervaded with a wholesome respect for "Franky's" caustic tongue; early days in the surgical wards under Mac's strenuous guidance; busy days in the Front; memorable going off nights; laborious days and nights as extern; cramming for finals, till we reach those days we shall never better, when we were "Charities for Peter."

2 Head beater.

Case of so-called Obstructed (really Strangulated) Hernia.

CLINICAL LECTURE BY Mr. SYMONDS.

February 5th, 1908.

Gentlemen,—I propose to call your attention to a case in which an irreducible hernia, being called "obstructed," while really strangulated, nearly led to disaster.

Notes from the Report of Mr. Khong.

H. F., æt. 46, public-house manager, was admitted on Sunday, January 12th, 1908, for a tumour in the right groin, with a history of his having found it, on waking in the morning, with pain. He says that twenty-five years ago a swelling first made its appearance, and was painful. He went into the Brighton Hospital, the swelling disappeared, and a truss was fitted. This truss he has worn ever since. It has been broken some time, and, moreover, he has grown to be distinctly stout. Though often down, he has been able easily to reduce the hernia. Four and a half years ago it again became painful, and was reduced by a medical man.

During the night of Friday, the 10th, the broken truss being on, the swelling descended, and he woke in the morning in pain. A medical man whom he consulted tried to reduce it, and the man made several attempts himself. Finding it no better, he came up and was admitted in the evening.

My house-surgeon reported the admission of the man whose case I have related, and as it is a matter of great importance, I will give the message as I received it, just to show the impression which a case of this kind conveys to those who have not seen a great deal of hernia, and, from reading, accept the idea of obstruction in hernia.

I was told, then, that a case of hernia had come in, the swelling occupied the groin, and the testis had never descended. The man was very comfortable, the swelling was not tender, there had been *no* sickness, the abdomen was soft, the pulse quiet, and he was inclined to sleep. So an ice bag had been applied, and symptoms waited for.

Now if there is one opinion I hold strongest, it is that no hernia should be allowed to remain irreducible for a moment if the means are at hand to effect its reduction. I sent on a message to prepare for operation, and I would be down at once.

Arriving about 10 p.m., I found the patient, a stout and florid man, looked quite comfortable, and, indeed, was dozing. Beyond the inguinal swelling, which gave no pain, and was only a little tender on handling, he showed no signs of distress. He gave a clear account of the events, and, moreover, the character of the swelling was inconsistent with chronicity.

The swelling had appeared from time to time, and was easily reduced. On two occasions in twenty-five years he had to send for medical help. He was clear that on this occasion he woke, in some pain, to find the hernia down and irreducible. He had not been sick, had not had sudden or severe pain, and had passed the fourteen hours since the descent mostly in bed, and in no discomfort.

The appearances were not like an ordinary hernia. The swelling was oval, and lay above Poupart's ligament. Its outer and iliac boundary was raised and abrupt, and did not, like the ordinary hernia, disappear into the canal. The lower limit reached the external ring. Such is the situation of a hernia occupying the serous sac, containing a testis which has not descended further than the middle of the inguinal canal. The swelling was hard, the contents did not shift on handling, and there was only slight tenderness.

It was spoken of as an "obstructed hernia" by my house surgeon, and an obstructed hernia is not supposed to be dangerous, and therefore may be left with an ice bag. This is a most dangerous and pernicious view to hold, when you are dealing with a hernia that is reducible at ordinary times. In an old irreducible hernia there is some truth in the statement, as I will presently mention to you, but if you allow such an opinion to influence you in the treatment of a recently descended and now irreducible hernia, you may let a patient go too far.

Taxis had been tried, and from the account carefully, before admission, and the man himself had tried to "rub" the swelling away as he had often done before. Partly on this account, and partly on account of the duration of the strangulation, we did not try taxis.

He was at once removed to the theatre, and when fully anæsthetised under chloroform, the swelling still remained irreducible, the tumour remained unaltered in character and size, and again taxis was not attempted. Mr. Digby performed the operation under my direction.

On opening the sac dark serum escaped, and then there was exposed a complete loop of dark purple small intestine. The wall was already thickened from extravasated blood and serum,

and in places the blood extravasation was black. The mesentery, thickened with œdema, showed many extravasations, and there were some greatly swollen glands. There was not only strangulation, but looking to the fact that the hernia had been down about fourteen hours, there was, for an inguinal hernia, severe strangulation. The rigidity of the mesentery and bowel made a large division of the ring necessary to effect reduction. The testis was not in the sac when opened, but slipped down from the abdominal cavity behind the hernia, after the stricture had been divided. The sac was dissected away from the front of the cord, ligatured at the internal ring and cut off. The cord was next ligatured in two parts, the testis removed, surrounded by the serous sac, and a radical cure of the hernia effected. The man made a rapid recovery, with primary union, and was not sick at all.

Look upon every irreducible hernia as strangulated, *i.e.*, every hernia which in the ordinary way is kept up by a truss, or, if a truss is not worn, comes and goes. In this sense the case I comment upon to-day was strangulated, and it proved to be severely strangulated.

The initial symptoms with which you are familiar were absent, *i.e.*, the sharp and sudden pain, the vomiting, the collapse.

They were absent because the hernia had come down slowly in the night through a large opening, because the loop was large and not tightly gripped, but the constriction was there, and as the vessels in the bowel became engorged and mesentery and bowel wall became œdematous from serous exudation, the obstruction to the circulation increased.

The difference from an ordinary hernia lies in the absence of sudden and complete strangulation, and so of the symptoms of shock. The patient never goes through this period, but comes before us in the second period, or that of "repose," which always follows the initial symptoms in ordinary strangulation.

To wait for symptoms in such a case is the worst possible surgery, and shows a want of appreciation of the danger of the situation. Greater still is this the case when you recollect that operation in such an early stage is absolutely free from risk.

These cases, where strangulation, and with it reflex symptoms, are slow in arising, are uncommon as herniæ go, but must be borne in mind. I have seen more than one such case pass into a condition beyond relief while symptoms were waited for. To recognise the ordinary case is within the capacity and experience of our ward clerks. Such cases as these must be remembered, and looked out for.

Adopt the golden axiom never to leave an irreducible hernia longer than is required to prepare for an operation. It may go back under anæsthesia; if so, well; if not, you must put it back by releasing the constriction. As to spontaneous reduction, let me say that in former years we used to give the anæsthetic —always chloroform—in the ward, and then stretcher the patient up to the theatre, and more than once have I seen the patient arrive there with the hernia reduced. The jolting movement, especially if carried upstairs, effected reduction. Is there not a good deal to be said for this sort of "taxis"? By lowering the head under full anæsthesia the weight of the intestines pull out the imprisoned bowel. It is well worth your trying.

What is an obstructed hernia? I will reply by asking another question. What is obstruction of the bowel under any circumstances? Let us get some notion of this condition as applied generally.

The familiar example is a stricture of the colon or rectum; a less frequent one, a stricture, simple or malignant, of the small intestine. Producing the same effect is compression of the bowel, as in pelvic cellulitis. In stricture of the sigmoid, obstruction may last three weeks, and then yield to operation. There is no strangulation of the vessels. A third, but differing somewhat, is the obstruction occasioned by adherent coils of intestine. Here the obstruction is due to over distension and folding of one or more coils, and if long continued the same effects arise as from strangulation, *i.e.*, infection and gangrene of the bowel.

Now, in a hernia we may put aside stricture, as existing in the large intestine, or small either. If present it is accidental. We have left, then, adhesion of the coils to one another and to the wall of the sac; but for this to occur the hernia must be always irreducible, or, at least, there must always remain an irreducible part. Here I admit that over-distension with gas may cause folding and obstruction—a condition relieved by ice, by gentle rubbing, by elevation of the pelvis, and this resembles the third form of internal obstruction referred to. But I am quite sure that, in a good many, the symptoms are caused by the descent of fresh bowel, held and constricted by the neck of the sac, and unless this possibility be kept in mind, cases will be lost by a belief in obstruction.

The most familiar example is that of an umbilical hernia. Here, more or less, the colon is always in the sac, and is adherent to the omentum, which lines the sac. From time to time the rupture is hard, painful, and the contents cannot be emptied as usual, and there may be sickness; such a hernia is said to be "obstructed."

I very much doubt the truth of such a conclusion, for whenever I have opened an umbilical hernia causing symptoms of strangulation, I have invariably found a coil of small intestine as the cause of the symptoms.

The colon is of normal colour; it is distended somewhat, because the small gut occupies and obstructs the hernial ring, but circulation can go on. In contrast, the strangulated small intestine shows up as a dark purple globe in the centre of the normal omentum.

Often reduced by manipulation, it is, I am convinced, this coil of strangulated small intestine that determines the symptoms in these old irreducible adherent umbilical hernia. Such conditions demand greater vigilance just because the strangulated loop cannot be felt.

In babies the scrotal hernia is often irreducible for short periods, and one may hesitate to call it strangulated. If left, however, the gravest results follow, just as in other cases. Though for the most part reduced by elevation and manipulation, or under chloroform, these are strangulated hernia.

We must abandon the term obstruction as applied to a hernia that is irreducible at ordinary times. There is no such thing. If you tie a string lightly round the finger you will in time get the same result as if it be tied tightly, but while relief will follow early release of a tight constriction, the secondary changes following the slow constriction may be too severe to be recovered from.

NOTE.—Since the above lecture was delivered, a man of 67 was admitted on February 8th with an ordinary inguinal hernia, with a history that he felt uncomfortable while working in his garden about ten o'clock in the morning, and found the hernia down. The truss had never been effective. He came in at 5 p.m. without pain, never having been sick; with a lax abdomen, a quiet pulse—in fact, just like the other case. The hernia was tense, and had the usual hard neck. I saw the man at 6.30 and ether was given at once. The hernia could not be reduced, and was, therefore, opened. A complete loop of tightly strangulated bowel was exposed, already granular, and of a deep red colour. A long piece of omentum was adherent to the bottom of the sac, and thus explained the ineffectiveness of the truss. The sac contained an unusual amount of serum. You will see that such herniæ are not uncommon. Sometimes these are diagnosed as omental hernia, and left for a time—a bad practice, as you can now judge from these two cases.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Fees in the I.M.S.

DEAR SIR,—With reference to your note on the regulations regarding the acceptance of fees from private individuals by officers of the Indian Medical Service, in the January number of the GUY'S HOSPITAL GAZETTE, will you allow me space to make a few remarks?

There was no intention, when the regulations were framed, to cast any stigma upon the service, or to interfere with the acknowledged right of officers to charge whatever fees they consider suitable under ordinary circumstances. Unfortunately, in every walk of life men exist who have no knowledge of the proportionate value of money, and the I.M.S. is by no means exceptional in this respect. There are officers belonging to it who, under cloak of their official position, are not as scrupulous as they should be, and who set an exorbitant value upon their services in trivial matters.

Those who are in a position to do so, know that such cases are not as infrequent as might be supposed. They agree that some control must be maintained to prevent malpractices, and that it is preferable that it should remain in the hands of the Head of the Indian Medical Service, who is better qualified to judge whether the fee demanded is proportionate to the service rendered, than extra departmental officers of the local administration.

Some heart-burning and loss of dignity must inevitably be felt in individual instances; but no one will, I think, deny that some such control is, under the circumstances, unavoidable, if the high reputation of the service is to be maintained. And the very knowledge that their charges are liable to criticism and review by the Head of their Department will make those officers who are tempted to place undue importance on their services more considerate of the position of their patients than they otherwise might be.—I am, etc.,

"ONE WHO KNOWS."

India,
February 11th, 1908.

BOOKS, &C., RECEIVED.—Confessio Medici; Goodhart on Common Neuroses; Maisonneuve's Experimental Prophylaxis of Syphilis: Williams' Minor Maladies and their Treatment; The Practitioner for March; The Annals of Surgery; The Journal of Balneology; The Australasian Medical Gazette; Nachrichten von der Königlichen Gesellschaft der Wissenschaften zu Göttingen; Proceedings of the Royal Society of Medicine, Vol. I, No. 4, February, 1908.

A Theory of Cancer.

A Paper read by Mr. LEE ATKINSON before the Pupils' Physical Society.

GENTLEMEN,—As science advances, so the conception of Chance occupying any place in Nature's regime recedes, and it is considered merely an evasion to ascribe any sets of phenomena showing universal similarity to "coincidence," or, as it is more popularly called, "Chance."

Of all the countless phenomena which various observers have noted and explained, at least three have scarcely been accorded the attention and consideration which their importance to biology and philosophy deserve. The uniformity of the physical and psychical rates of development, and the uniformity of stature and of longevity of the human race, are facts which call for an explanation, and if such could be adequately given there is reason to believe that, amongst other advantages accruing, a great advance could be made in the knowledge of the causation of most pathological processes.

In the physical universe all motion obeys the three great laws enunciated by Newton, and day by day biological science is acknowledging that her phenomena act in accordance with physical laws, so that it is not presuming too far when the suggestion is put forward that, *mutatis mutandis*, all the biological phenomena concerned with motion in any form obey laws similar to those of Newton's.

Now growth is evidently a form of motion, and may be ascribed to the effect of a force (referred to hereafter in this paper as the "growth-force"), and in accordance with the first law, which states that a force acts continuously and uniformly unless opposed by or augmented by another, it must be assumed that this growth-force is a perpetual one, and that unless it were counteracted would attest its influence continuously, with the result that the process of growth would be perpetual and there would be no limit to the increase in size of an individual throughout life. Common experience shows this to be untrue, as all men conform to a comparatively uniform height, and moreover, that in all men the phenomena of growth apparently ceases at a more or less definite period in their life cycle, usually in the fifth hemidecade. These facts at once raise the question as to why the growth-force should cease to act, and at once the probability of another and antagonistic force arises.

In looking at the curve representing the rate of growth of an individual from the fertilised ovum to the fully-developed adult, it is at once evident that the period of greatest activity is the intra-uterine existence, when the increase in length from a decimal of an inch to twenty inches in the short space of nine months is a rate which is never approached again during the life cycle, and although the remainder of the curve up to the age of twenty-five is not perfectly level, yet the inequalities are small enough to permit the curve to be called one representative of the acquisition of equilibrium between two unequal forces, of which one, from being almost negligible at the outset, yet augments itself till it completely neutralises the effect of the other, a position of equilibrium results.

The questions to be considered are—How is it that these curves represent the physical and mental growth of practically every human individual? Is it chance, or is it the effect of some universal force or forces?

The question of chance will not be discussed, because to admit this solution would obviously be to admit a negative answer; and so it is the aim of this paper to produce reasons for believing that it is the result of two antagonistic forces, which, *mutatis mutandis*, obey Newton's three laws of physical forces, producing a condition of unstable equilibrium, which is the real cause of all disease.

These two forces will be referred to as the growth force and the death force respectively.

It is universally accepted now that all tissues are composed of cells consisting of a substance—protoplasm. This substance is regarded by some as merely an obscure chemical complex, and by others as consisting of known elements, but depending upon its characteristic properties on an unknowable but essential property referred to as vital force. For the purposes of this paper it makes no difference which is accepted, for in either case it is acknowledged that protoplasm has certain well-defined properties which always persist, and which must be present, and that under any given set of conditions this substance will always react in a certain way.

In the highly elaborated and specialised tissues composing the human body, the protoplasm of each develops one particular property to an extreme degree, and to a corresponding degree loses practically all the others. For example, a nerve cell, although consisting of protoplasm (as shown by its products of disintegration) never exhibits any such characteristic as reproduction of itself, and although Sir William Gowers has described sleep as being due to a retraction of the dendrons of the brain cells, no other observer has yet suggested any motile power to such a cell.

Now, one of the accepted properties of protoplasm is its power to maintain its constitution by means of its metabolic powers, and hence its chemical structure must ever be unaltered. Other things being equal, a tissue, as it has its own specific constitution, can only act in one way, and that is called for each tissue the normal. This would be embodied in the following paraphrase of Nature's first law of motion.

"Every body continues in its state of rest or of uniform motion, except in so far as it is compelled by external impressed force to change that state."

The truth of this, logically, must be axiomatic, for if the protoplasm of any tissue, by its own intrinsic powers, preserve its composition constant, all its reactions must be constant. From this follows the deduction that whenever a tissue fails to react normally, as in the anæsthesia, or palpitation of the hysterical

person, as well as in all the well-known and so-called "organic diseases," it is not a normal tissue behaving abnormally, but an abnormal tissue behaving in a correspondingly abnormal manner, this manner returning to the normal when the normal equilibrium of the tissue has been restored. Clearly, then, if all the other conditions are unaltered, a tissue should continue to function normally without interruption, But tissues do not function normally for ever, and so the conditions influencing them must be subject to some change, and it is now the place to examine the conditions influencing a tissue. All tissues are under a double influence, one part of which regulates and controls their functions, while the other regulates and controls their composition.

The nerve supply to every tissue, even if not actually demonstrated, is known to be a fact, while the fact that every tissue element is surrounded by lymph or some similar fluid is one of the first things learnt in physiology. So now an equation can be made representing the equilibrium produced in a tissue cell—

$$N + V + K = F.$$

where N = nervous influence, V = vascular influence.
K = a protoplasm constant when it is fully active.
F = the normal function of the cell.

An important point to observe in this equation is the symbol K, for on it largely the theory being advanced depends. K is described as being a protoplasm *constant*, and it is intended to signify by that the sum total of forces inherent in the cell, and which by the adaptation of Newton's law, referred to above, must act continually unless interrupted by some external impressed force. The importance of fully acknowledging this lies in the fact that if this be granted, and it must be logically, a force cannot arise *de novo* in the cell, the only elements of the equation which are the primary variables being N and V.

On proceeding to a further investigation of these facts, another and scarcely less interesting point comes to light, and that is that N is not a primary force at all, inasmuch as it depends for integrity of action on its own blood supply, and of all tissue none responds so sensitively to any alteration in the quality or quantity of the blood supply as does the brain and nervous system; so that although the nerve supply to a tissue is essential for its maintenance of a healthy and normal function, yet this nervous influence is again dependent on its own blood supply, and probably reacts more quickly to any change therein than the particular tissue in question. The influence of the nervous system over the tissues is undoubted, and many observers, amongst them being Sherrington, Schiff, and Mead, have described a "trophic" function of the nerves, on the integrity of which depends the normal health of the tissues.

The fact of this dual control of tissues suggests a practical application for the following theory:—Growth cannot be a haphazard process beginning with the fertilization of the ovum and ceasing at some ill-defined period of life of its own accord, for to assume such an hypothesis would be against all the recognised laws of Nature. Growth must be regarded as a natural force compelling the various cells to divide and modify themselves according to their particular situation. A force, it is agreed on all sides, must continue operating in a uniform way until it is affected by another force, whether that be accessory or antagonistic, and if growth cease it can only do so by having its influence antagonised.

It would scarcely be considered logical to conceive two mutually antagonistic forces acting through the same field, and so the antagonist of the growth force must have its seat of action elsewhere, and the next step is to locate this.

For many years past now, physiologists have been working at the theory of "internal secretion," with the result that several of the ductless glands, hitherto suppo ed to be functionless, have now well-defined functions attributed to them. The term "internal secretion" was first used by Claud Bernard to explain his theory of the glycogenic function of the liver, and was subsequently extended by Brown, Seyward and Schiff to other ductless glands. Then that most useful of all the practical medical sciences, Pathology, stepped in, and correlated certain symptom complexes with constant and well-defined changes in these ductless glands, formulating theories of the pathology of such diseases as Addison's disease, acromyaly, goitre, and many others, which all recent research seems to confirm in every detail.

This work has been pushed very much farther by a host of workers, and at present not only the various ductless glands, but other organs also, such as the kidney, the ovary, the testis, and others, have been regarded as possessing internal secretion. It is the function of these internal secretions which are of importance to this paper, for it is found that all the known ductless glands give to the blood, or perhaps remove from it, some substance which controls the metabolism of some particular tissue, or set of tissues, in the body, and if absent, that particular tissue shows a tendency to overgrowth and impairment of function. Hence it is obvious that the blood, as it circulates through the body, is modified in certain ways and in definite situations, so that it regulates the growth of the various tissues. Again, it is noted that the various ductless glands have different periods of activity, and the thymus may in all probability control some mechanism in the fœtus and infant which is modified in childhood, so that no control is needed, and the thymus atrophies.

These facts are sufficiently strong to allow the theory to be proposed that *it is in the blood that the inhibitory force of the growth force is located, and that during childhood and youth the two forces interact and permit of growth until a certain age, when they reach a position of equilibrium and neutralise each other, but both forces persist because they must, from their very nature, be perpetual, and if by any cause the equilibrium be disturbed, then the stronger force, whichever it may be, exerts its influence again.*

The age at which this equilibrium is reached differs according to the species, but it is a remarkable fact, and one quite in harmony with the other coincidences remarked earlier in this paper, that for every member of each species the age of cessation of growth is practically the same, and, with the expanding influence of Spencer and Darwin, it is not at all presumptuous to suppose that the explanation of this fact can be found in "Evolution"—"the survival of the fittest."

The position of overwhelming importance occupied by the blood in the modern pathology is undoubtedly due, in large measure, to the genius of Ehrlich and Metchnikoff, and whereas in comparatively modern books on physiology and pathology the blood was described in a few pages, in recent literature, owing to the discovery of hæmolysins, agglutinins, precipitins, amboceptors, and the countless other bodies it is found to contain, the blood requires not one volume for its complete description, but several, and every day fresh facts are brought to light revealing its latest secrets. This strongly confirms the object in hand, which, to put it in a few words, is to prove that life, growth, death, *and the entry of all disease into the body are due ultimately to some particular state of the blood.*

The blood in the animal economy holds the unique position of being a living tissue, in which the number, kind, and proportion of its constituent parts are necessarily in a constant state of change. This change is undoubtedly due, in the first place, to the fact that it is the only part of the organism which can in any way, except by gross injnry, be altered by substances from without the body. In the alimentary tract the blood is constantly absorbing a countless variety of substances which have been ingested, mostly for the purpose of nourishment, but some also accidentally. To enable its absorption of food it stimulates certain cells in the various chambers of this tract to pour out secretions, which attack the complex bodies and disintegrate them into simpler ones, which are easy of absorption.

Now all the various secretions, although they may be, and probably are, elaborated in the particular cells of the various glands, yet they must obviously all be ultimately derived from the blood which brings them the raw material for them to elaborate.

In making these statements it has not been overlooked that the nervous influence over all cells must remain intact, for it is acknowledged that the results are gained by the harmonious working of the two universal forces postulated, working through the two different paths, the blood system and the nervous system.

To resume, it is seen how the blood provides for the efficient nourishment of the organism in health, and now it must be suggested that the blood also provides for the preservation of that health against disease. There is no intention here of repeating the well-known theories of immunity, but the point is to show that, by the preceding arguments, any cell in the body can only be attacked by disease when a change in the constitution of the blood takes away its safeguard from that disease.

There is a peculiarity in immunity which may have escaped the notice of some people, and that is, that the so-called "natural immunity" of the individual only safeguards him against those diseases which are natural to his environment, and that in the case of foreign diseases his resistance is very weak.

This statement of the rôle of the blood in the whole life history of an individual not only comprises its chemical and physical constitution, but of course includes all the phenomena of phagocytosis, diapidesis, and every other action of the blood-cells, as they are all due to the action of the plasma.

Time does not permit of a fuller discussion in this place of the facts in support of this theory, and only the bare facts have been stated; but it is hoped that one day much more evidence will be adduced to establish the theory of the blood as the ultimate and predominating factor of all life and disease.

Now the theory postulated above is to be applied to the Problem of Cancer, to see if from a purely *à priori* argument a possible explanation of the cause of cancer can be deduced. It was suggested that logically the growth-force must be an ever-present and an ever-active (potentially) force acting along the nerve paths and previously recognised as the trophic influence of the nervous system; also that its action was being perpetually inhibited by an antagonistic force in the blood, which derived it in the course through the ductless glands. In the adult where these two forces are in equilibrium and growth has ceased, the action of the growth-force is neutralised by the equal and opposite reaction of the blood-force, and this is illustrative of Newton's third law.

But supposing that for some reason a diminution of the blood-force occurs, what result will that have on the organism? To borrow an expression from Ribbert, although more than probably it will not be used to convey precisely what he meant, yet the words "tissue-tension" will serve to express quite definitely what was implied by the equation—

$$N + V + K = F$$

in which N and V are the variables, and on their respective values K and F depend.

The theories of cancer formation are numerous, but comparatively only few have gained any wide acceptance, and for the purpose in hand, the following are the essential ones:—

(1.) *Cohnheim's* Theory of Embryonic Remnants.
(2.) *Virchow's* Mechanical Irritation Theory, and
(3.) *Ribbert's* Growth Liberation Theory.

This last theory is so like the one here propounded that some especial attention must here be paid to it.

According to Ribbert, "in every tissue cell there is a capacity for growth and regeneration which is held in check by the tissue-tension;" but nowhere can be found exactly what is inferred by the term "tissue-tension," and this is naturally a point of fundamental importance. Then the theory proceeds that "if cells singly, or in groups, be completely or even only partially cut off from

their original tissue," *i.e.*, lose their organic continuity, "the restraining influence of the tissue-tension is removed, and the cells multiply."

In Ribbert's theory there is at least one vital point that other observers do not appear to corroborate, and that is the suggestion of the removal of organic continuity as the starting-point of a tumour formation, and although by no means inconceivable, it is at any rate improbable, and a more likely factor disturbing the "tissue-tension" is needed. The theories of Cohnheim and Virchow both postulate a good point of attack for the neoplasm.

During the past few years Loeb and his school have been making some important experiments concerning the effects of attenuated solutions on the growth of cells, and in this country Moore, Roof, and Whitely, in studying the acidity of the stomach in carcinoma, have been led to make similar experiments, and they attribute this effect upon the growth of cells under these conditions to ionic action. Loeb, using the eggs of the Echinoidea, found that on adding a solution of Na.CL, in a strength of 1 in 100, to sea-water, noticed that their rate of growth was greatly increased, and not only that, but that the growth was no longer regular, the cells produced being of varying sizes, and the nuclei showing atypical mitoses. Now a single cell combines in itself, although in a similarly reduced degree, all the essential functions of the highest and most complex organisms, and the growth-force here is an integral function of the cell, so that the sea-urchin's egg would have a tissue tension between this same "growth-force," and the condition of the normal sea-water, as regards the osmotic pressure and ionic condition of the last. If this tissue tension be disturbed in a certain manner by the addition of a solution of a salt in which the anion is the predominant ion, in a sufficiently low concentration, the cell is stimulated by the abeyance of the inhibitory action giving the "growth-force" opportunity to arrest itself, which it does; and being uncontrolled the strictly typical divisions are no longer adhered to, and heterotype mitoses result.

Some attention, I believe, has been drawn at times to this form of heterotype mitosis resembling that of cancer, but now I want to suggest that it is not a mere resemblance, but that one is identical with the other, and that, to put it shortly, the cause of the growth of a neoplasm is the presence in the blood of an anion derived from its normal components which, acting on a tissue from a certain cause, neutralises the inhibitory action of the normal blood, and gives free play to the ever-present and ever-active "growth-force," resulting in the production of many new and perhaps atypical cells which collectively form the neoplasm. Having made this suggestion, it is now only proper to examine it with a view to deciding how far it will conform to the known conditions of the growth and structure of cancer.

In pathology a neoplasm is distinguished from mere hyperplasia by the possession of at least five characteristics :—

(1.) It begins in a focus, and retains that focus always.

(2.) It has a tendency to disseminate to other organs and tissues.

(3.) Although it often resembles in structure the tissue in which it has its focus, yet it does not necessarily do so, but may represent an embryonic form of that tissue.

(4.) It seldom shows the retrogression of inflammatory hyperphasia of other growths, *e.g.*, syphilitic gummæ.

(5) There is always a complete absence of function.

Now, considering the first point—its origin and preservation of a focus. It is in this place that the importance of Cohnheim's and Virchow's theories enters, for they supply the last essential condition for our hypothesis. Given the persistence of "growth-force," and the removal of its inhibition by the blood, why is there no general resumption of growth everywhere in the body? This is only an apparent obstacle, for all the tissues do not possess the same scope for action of the "growth-force," for, as Cohnheim has so conclusively shown, the places in the body where embryonic remnants exist are always places where new growths show a tendency to appear, and amongst many examples the best illustration is that in the case of bony exostoses; their seat of growth is nearly always in the neighbourhood of the epiphysis, or centre of most active growth.

Trauma, as a possible cause of cancer, has often been discussed, and has several supporters still, but its opponents are sometimes led into error by asserting that cancer can exist in parts where the possibility of trauma is negligible, and seem to overlook that it may be only an incidental and occasional cause. The frequency with which one obtains a history of a blow in the cases of mammary scirrhus is strongly suggestive of its traumatic origin, and hence, when all these are considered, the evidence of a local trauma as being a "cause" of cancer is very great, but a better term for it than "cause" would be a predisposing condition.

Another predisposing condition which suggests itself from time to time is "heredity," and the cases where mammary and uterine malignant growths reappear in the daughter of a mother who has suffered from these affections, draws the question of heredity into the arena, and this is made more prominent by the fact that where the woman has had a blow, followed by a mammary cancer after the birth of the daughter, the daughter shows no tendency to the inheritance. Now, an inflammatory process following a blow, or a tendency to active growth under certain conditions in these embryonic remnants, would cause a modification in the blood supply to the part, and the observation has long since been made that in cancer a blood examination reveals hæmocytosis, and this hæmocytosis, by withdrawing a slight amount of acid from the nuclei (which eventually disappear as normally in the crythrocytes), would tend to slightly increase the alkalinity of the blood, for the acidity of the nucleus is always slightly in excess of the alkalinity of the cytoplasm, and this new alkalinity of the blood acting with the "growth-force," on the seat of already weakened tissue, would probably act in the same way as the salt solution in Loeb's experiments, and cause

a rapid and irregular production of the tissue cells of the part, and would not cause a formation of heterologous cells of which there was no existing counterpart in the body, but would simply cause an increased production of the already extant cells. That the alkalinity of the blood is actually increased in cases of malignant growth, has been proved by the researches of Professor Moore and Mr. Wilson, who found that using di. methyl. as an indicator, the average alkalinity of normal blood is 0·176, whereas the alkalinity of the blood in malignant growth is 0·208.

Before attempting further to show how this theory fits in with the other accepted conditions of cancer, an inquiry must be made as to whether the process outlined above would tend to produce a typical neoplasm. It is generally accepted (Condition 3, above) that a neoplasm shows in its structure the essential characteristics of the part in which it has its focus, but that the elements are in a less perfectly developed form. Now, however differentiated the cells of a fully-formed organ may be, in the early embryonic states all cells bear a remarkable resemblance to one another, and it is only during their further development that they assume their typical and distinctive characteristics by which they are eventually differentiated, and so it is quite in accordance with our theory to state that when, at some period of the life of an organism, the "growth force" is again liberated by a particular condition of the blood, that the cells of the focus of the force should again multiply and produce, not the typical fully-developed tissue cell, but the typical embryonic tissue cell, which may, if left long enough, so far develop as to bear a distinct likeness to the fully-formed cell. That this process should occur more quickly than in the case of the development of a normal cell, is readily conceivable when one notes the results of Loeb's experiments. Taking some ova of the *Echinus esculentus*, he fertilised some at 9.30 in the morning, and divided them into three portions, one of which he left in normal sea-water, another portion in sea-water to which a 1 per cent. solution of Na. Cl. had been added, and a third in sea-water to which a 2 per cent. solution of Na. Cl. had been added. In the case of the first portion, cell division began in a quarter of an hour and proceeded normally. In the case of the second portion, cell division did not begin till the end of an hour, and then he transferred these to normal sea-water, where they at once divided rapidly and irregularly, and soon nearly overtook, but never quite, the cells of the first portion. The eggs in the 2 per cent. solution with sea-water did not develop at all. He sums up the result of these experiments in the following manner:—"If we reduce the irritability of the protoplasm of the egg by reducing the amount of water contained in it, the nucleus can segment without segmentation of the protoplasm. If we increase again later the amount of water, and consequently the irritability of such an egg, the protoplasm at once divides into about as many cleavage spheres as there are nuclei formed. The segmentation of the protoplasm in the egg, and *probably in every cell*, is only the effect of a stimulus originated, as a rule, by the nuclei."

Hence, admitting the truth of the theory, the known facts of cancer are in no way controverted, but lend a very strong support to it. In the case of sarcoma—where are distinguished the round and spindle-celled varieties—the relations of the various cells to the embryonic tissue, and the fact that the quicker the growth the more evident the likeness to embryonic tissue (so that the more slowly growing cells tend to elongate), bear strong support to the theory; and this is still further strengthened by the fact that these tend to organise into tissue which is very hard to differentiate from ordinary connective tissue.

In following up the comparison, it is evident that the rapidly dividing cells lying in a hyperæmia area would not be able to resist the mechanical flow of the lymph, which would sweep some of them away to the lymphatic glands, and further even to other tissues, and that, on their arrival, the tendency for them to grow would result in a secondary deposit, which in structure would represent that of the structure from which it originated, and hence the fact that secondary deposits occurring in bone in cases of, say, a mammary scirrhus, would have a typical mammary glandular conformation. As to its powers of retrogression, the dogmatic assertion that a true cancer never retrogrades demands investigation. Sir Victor Horsley has found that on trephinning the skull and finding an inoperable tumour of the brain, and leaving it alone, it has, at times, idiopathically disappeared, and not a few authenticated cases of inoperable cancer have been recorded which have cleared up without any direct treatment. Thus the inability to retrograde as a characteristic of true cancer must be modified.

A suggestion could be thrown out in these cases that the operation by hæmorrhage, or as a result of the subsequent inflammatory processes, rectified the condition of the blood, or altered it in such a way that the "growth-force" is checked; this can easily be done in the case of eggs, as Moore has shown that the addition of a solution of acid or alkali, .002 normal, causes complete cessation of growth, so the influences of minute differences is enormous, and is explicable by the physical fact that the diluter the solution the more complete the ionisation of the electrolytes, and the ions are the essential factors in the blood influence, inhibiting the growth force. Roaf, in an account of his work in conjunction with Moore and Whitely, states that the hydroxyl (OH) ion is the stimulus to growth, and, in commenting on the growth of sea-urchins' eggs, he says, "that upon altering the reaction of natural sea-water in which the eggs were growing, that the addition of alkalis or alkaline salts favours cell-division when added in sufficiently small amounts, but that on increasing the strength the growth becomes arrested, while acid and acid salts possess no favouring action, but inhibit the development of the eggs throughout.

The last essential condition for a growth to be of a cancerous nature is the absence of function, and the

embryonic or otherwise irregular character of the malignant tissue is amply sufficient to account for this defect.

The parasitic theory of cancer has been worked at by an array of clever workers, and the results at present are far from convincing that the cause is a micro-organism, for the following reasons:—(1) That no parasite has yet been discovered which is definitely associated with one definite type of cancer, let alone with all, in spite of the "Psorosperus," and even M. Doyens' "micrococcus neoformacs." (2) That by all the methods known to bacteriological and toxicological science, no serum, toxin, or other substance has yet been found which in any way affects the course of a growth. (3) That none of the typical clinical symptoms of a severe parasitic invasion are evinced in the case of a cancer without any intercurrent malady, except in the latter stages when metabolism is failing.

Much attention has been drawn recently to the work of the Cancer Research Association. The results published by Bashford show that cancer can be inoculated into one mouse from another. Some observers regard these facts as evidence in favour of a parasitic theory; but is it not possible to regard them in the same light as secondary deposits in an individual, and recognise in them a mass of cells having an abnormal tissue-tension, which again shows its loss of equilibrium in the new situation by renewed growth?

Hence, although it would be extremely rash, in spite of such almost overwhelming evidence, to assert positively that a parasitic cause of cancer is impossible, yet, considering the extremely novel conditions it would have to fulfil, it is in the highest degree improbable. But, on the other hand, the idea that the cause of cancer lies in the blood is by no means a new one, and has for its great support the fact that the blood is the great nutritive agent of the body, and that all modifications in it, beyond the trifling physiological ones, are always fraught with grave danger to the organism.

Theories have been brought forward that in the blood there is a mixture of tissues which in certain people, under certain conditions, can evolve "a residue" which is the neoplasm, and again others have attributed the growth of a cancer to an "organising power" in the blood. Sir James Paget has said, "I think malignant tumours are local manifestations of some specific morbid materials which accumulate in the blood, and which their growth may tend to increase." Professor Moore, Roof, and many other observers have shown a definite decrease in the gastric hydrochloric acid in cases of malignant disease, and the chemistry of this acid is at present believed to be bound up closely with the sodium chloride of the plasma, a fact which will be referred to later; but Moore and Wilson carried out a large number of experiments on the basic reactivity of the inorganic salts of the blood serum, and the following figures are the averages of a large number of observations:—

(a.) *In malignant disease.*

Male	=	0·0318	normal.
Female	=	0·0316	„
Average	=	0·0317	

(b.) *In healthy people.*

Male	=	0·0304	normal.
Female	=	0·0306	„
Average	=	0·0305	

(c.) *In other diseases.*
(Including tubercular hip, knee, shoulder, diabetes, chronic mastitis, mammary abscess, psoriasis.)

M. — F.	=	0.0297	normal.

In summing up his conclusions on these observations, Moore says, "The percentage of hydrochlorine acid is very sensitive to the general condition of the body, and is generally reduced in all cases of illness or enfeeblement. In addition to this, in malignant disease there is a more pronounced drop in the degree of acidity, so that in the majority of cases free hydrochloric acid is entirely absent, in practically all cases there is a very marked reduction."

Recently, in glancing over some back numbers of the "Lancet," for any additional facts to support this theory, I found a series of papers by Dr. Harry Campbell, entitled, "The Blood Plasma and Disease," in which the suggestion I had here made as to the all-importance of the blood was discussed at full length, and the specific action of hormones and such bodies was clearly defined. Even the integrity of the nerve-supply to a tissue depending upon the blood supply to the nerve-cells was noticed, and so I wish to adduce these papers in support of the theory.

Again, Metchnikoff, in his new book on the "Prolongation of Life," quotes Dr. Lorand as having advanced a theory in which death was regarded as supervening on a failure of the ductless glands to function properly, although both he and Lorand seem to regard the suggestion as a minor one.

But of far more importance is the next and last authority I shall quote to-night, for, by a cross-reference, I was led to turn back to the Guy's Hospital Reports for 1858. It is Vol. IV. of the Reports, and therein is a paper by the President of this Society, then Samuel Wilks, M.D., in which he makes the following statements, which, if this theory be correct, are strangely prophetic. In referring to the malignancy of tumours, he says, "Let us enquire, in the first place, what determines the presence of an adventitious growth in the body. Two causes are in operation in different cases, a local and a constitutional; and upon the separate action of these do we have the extreme forms of benignant and malignant growth, and upon their combination do we have the great number of their intermediate varieties. The first cause alone in operation has a tendency to the formation of tissue allied to the healthy structures, whilst the latter has simply a power for the production of the simplest elements as seen in the malignant

growths. In the one case the tendency is to a formation process, and the nearer this approaches to the natural one the more benignant the structure, while in the other case the tendency to the production of cells such as existed in the embyro preceding the formation of the tissue, and, therefore, if such embryonic cells spring up and continue to grow in the perfected body, we have a cancer, a cancerous tumour being simply a mass of embryonic cells. Our meaning is this: that, in the healthy organism, the blood maintains in integrity the different structures of the body, every part, however complex, we believe, is constantly being renewed. This is due to some close affinity between the textures and the blood ingredients."

Summary.—Now, in conclusion, I wish to sum up the arguments and present to you the fully-formed theory, which is that the growth of the organism from the fertilised ovum is the result of a constantly acting natural force, referred to as the "growth-force," which is perpetual and ever present, but which, when the organism has reached that state of bodily development which is best suited for it to participate in the struggle for existence, is inhibited by certain substances in the blood, these substances being the internal secretions, and the like, of various glands and tissues. If for some extraneous local cause this equilibrium between the growth-force and the blood-force be disturbed in a certain way, the growth-force exerts itself unchecked, and from the tissue cells of the focus of the disturbance a multiplication of the cells takes place resulting in a neoplasm. That these foci may be embryonic, remains, as suggested by Cohnheim, and supported by the fact that such remains always have a tendency to proliferate like the meristomatic tissue in plants, and by the fact that in tissues with a part more definitely active than the rest, such as the epiphyses of a bone, it is at this part that the new growth develops.

The preference of a new growth for some particular spot is a problem really outside the province of this paper, but is probably due to an intonine selective power on the part of the cells of that part, or possibly it is a part very exposed to mechanical irritation, *e.g.*, the preference of an exostosis for the distal phalanx of the hallux.

The fact that ionic action has a most marked influence on the cell division, as propounded by Loeb, Moore and others, suggested that if an ionic disturbance of the normal pressure in the blood could be proved, that this would be a good working hypothesis for the formation of new growths. This ionic disturbance has been conclusively found to exist in the form of an increased alkalinity of the blood, and of a decrease of the acidity of the stomach (although it is not forgotten that the Na.Cl. is a neutral salt, yet nevertheless the Cl. ion overpowers the sodium, and so its action is positive towards the cell growth), and hence theory and observation so far coincide.

Gentlemen, in putting before you this theory, I can assure you that the remark made to Marie Antoinette has been ever present in my mind, "Madame, nothing is new, save that which has been forgotten."

Sport.

Rugby Football.

GUY'S v. BART.'S.—2nd Roufd.

This game was played at Richmond on February 24th in a hurricane, and resulted, after an extremely exciting and fast game, in a draw, neither side scoring. In the first half our men had the better of the game, but much to the general surprise the Bart.'s forwards beat ours for the ball; neither side at any time looked like scoring.

In the early part of the second half Bart.'s looked dangerous as the wind moderated; the superior condition of our forwards told, and though all shone to advantage, no score resulted, We were severely handicapped by the retirement of J. P. Jones in the second half; his knee, injured in the Plymouth match, giving way.

Remarks.—Duke gave an excellent display under conditions which were anything but favourable. Both Stringer and Lee played good games. J. P. Jones, owing to his knee, was not up to his usual brilliant form; nevertheless, considering his great disadvantage, he played a splendid game. Our forwards were undoubtedly better in the loose, but Bart.'s time and again beat them in the scrum. The halves had not many chances.

GUY'S v. BART.'S.
Cup Tie (Replay).

Played at Richmond on February 4th, and resulted in a win for Guy's by 10 points to 3. A great game, and a dramatic finish! After the kick-off Bart.'s forwards went very strong, and our men were kept frequently on the defensive. Then happened, what may be termed, a fearful streak of luck for the Smithfield team. Coombs attempted a cross-kick, the ball struck the bottom of the post, three of our men were behind waiting to touch-down, luckily the ball rebounded to With, who had merely to pick up and score. Bart.'s forwards were playing a most strenuous game, and it was a battle royal between two good packs. Our team bucked up considerably, but no score eventuated. Half time was called with 3 points against us.

Shortly after the second half commenced, Stringer, following up well, set up a hot attack, which ended, however, in an unsuccessful drop at goal by Duke. Our forwards were now getting the ball, but the Bart.'s defence was excellent—Duke brought off a good collar, bringing Gibson down near the line. Lee was putting in some excellent straight runs, but was often unsupported; but ten minutes remained, and Bart.'s led by three points. Suddenly, near our own 25, Stringer and Lee initiated a good rush, and after an excellent bout of passing amongst the backs, the first-named player reached the Bart.'s 25 line; here he passed inwards, and Archer, with an excellent dribble, just beat the Bart.'s back, and touched down. The try was not converted. But six minutes remained, and the score was three points all! The excitement was intense. Shortly after

J. P. Jones, who, in spite of his injured knee, was playing a characteristic game, kicked towards the Bart.'s line—our valiant forwards, whose excellent condition was standing them in good stead, followed up well—the Bart.'s back, flustered, made a poor low return, the ball going to Saner, who, amidst indescribable excitement, ran in and touched down. There was no conversion by Saunders, but at the very last minute, Jones made an opening for Stringer, who "dropped" a neat goal. The whistle went immediately after.

Remarks.—Duke we have seen play better; of the threequarters, Lee, undoubtedly, played a great game, his straight running and good kicking being an outstanding feature of the game. J. P. Jones, as usual, was the mainstay of our defence, and his kicking was excellent; we congratulate this player on his exhibition considering the adverse circumstances. Stringer, though missing several passes, played an excellent game, and it is entirely due to the bout, initiated by this player and H. Lee, that our first try was due. Digby was slow. Saner and Pritchard were not quite as fast as they might be, and both these players, in the open, should learn to run straighter. Of the forwards, one and all played a good strenuous game. Archer, Crook, Saunders, and Hoby, being conspicuous. As in the first game, the superior condition of our pack had much to do with the victory.

Team.—H. L. Duke (back); Stringer, J. P. Jones, Lee and Digby (three-quarter backs); J. G. Saner and Pritchard (halves); Crook, Archer, S. McK. Saunders, Mullins, Pinching, W. Williams, Hind and Hoby (forwards).

In the first game Saner played on the wing in Digby's place, while L. Cane was half-back.

Final against London to be played at Richmond on the 12th.

GUYS v. PARK HOUSE.

This match resulted in a runaway victory for our team by one goal, two dropped goals, and eight tries (37 points) to nil.

The game against the United Services to-day has been scratched.

STOP PRESS.—Guy's, 12 pts., St. Mary's, nil.

Association Football.

GUY'S v. BART.'S.

Inter-Hospital Cup.—2nd Round.

The replay of the second round, which had previously ended in a draw, gave to Guy's the right of having the game on their own ground. Consequently on Wednesday the Bart.'s team arrived at Honor Oak Park. The game was delayed until one of their forwards appeared, but soon after 3 o'clock the ball was kicked off. Guy's had the greater part of the game from the beginning, the left wing being stronger with P. Humm as outside, and A. H. Crook as the half-back, so that some quarter of an hour from the commencement a goal was scored by Whiteley, after some excellent passing between himself and Birks. Later Birks himself added a second goal, and the game continued until half-time without any alteration of the score.

In the second half play was quite fast, King, at outside right, centreing with great precision, whilst on the left wing the Bart.'s opposing back was somewhat damaged, being only able to move about slowly. This weakened their defence greatly, and Whiteley and Birks added one each to the score. The rest of the game still showed play in our opponents' half, and Whiteley shot two more goals. Bart.'s, however, got away from a fortunate miskick, and Gordon, their left inside, scored. The game terminated with this result—Guy's 6 goals, Bart.'s 1.

Team.—C. A. Wood (goal); H. R. Bastard, C. H. Mills (backs); P. V. Pedrick, F. W. Denning, A. H. Crook (half-backs); R. M. King, C. E. Witts, W. F. Whiteley, A. H. Birks, P. Humm (forwards).

GUY'S 2nd XI. v. BART.'S 2nd XI.

Inter-Hospital Cup Tie (Replay).

The second meeting of these teams took place at Winchmore Hill on Saturday, 22nd February. A gale of wind was blowing diagonally across the ground, and Guy's winning the toss, started with this in their favour. Bart.'s at once started to attack through their centre-forward and inside left, but were brought up, not only this once but innumerable times by the steadiness of Hole and Johnson at full-back. Guy's forwards never got together well, but from one of many rushes Lewis Jones scored, somewhat luckily. Just after this Eccles was damaged, and for the rest of the game was a passenger at outside left, Mitchell coming inside. Nothing more was scored before half-time, when Guy's crossed over to face the wind and a blinding rain with a score of 1–0 in their favour.

The second half was simply a game of kick and run owing to the state of the ground, and the wind and rain, and in such a game Guy's superior defence gave us the match. Our forwards were continually dangerous from individual rushes, and added 3 more goals, Cook, Wain and Lewis Jones being responsible for them. Just before the finish Bart.'s scored their only goal from a long shot which just scraped Hole's head en route. Guy's thus won a hard game by 4 goals to 1, and qualified to meet London in the semi-final.

Team.—H. C. Rook (goal); W. Johnson and K. H. Hole (backs); J. A. Edmond, H. V. Gibbons, T. J. Keer (half-backs); W. W. Cook, W. Wain, H. N. Eccles, T. Lewis Jones and D. A. Mitchell (forwards).

GUY'S 2nd XI. v. LONDON 2nd XI.

Inter-Hospital Junior Cup.—Semi-Final.

Played at Chiswick, on Wednesday, March 4th, resulting in a win for us by 2—0. The teams were fairly well matched as regards weight, London, however, being heavier forward than we were. The first half was well

contested although, if anything, Guy's did more pressing. We had one or two narrow escapes at scoring before our first goal was actually registered, some half an hour from the beginning of the game. This was neatly headed in by Mitchell from a corner kick, which Cook placed beautifully in the goal mouth. London started off with a rush after this, and Hole just succeeded in intercepting their centre-forward when he looked like scoring.

Guy's kept up the pressure, and in the second half had it mostly their own way, the ball being kept well in London half. The forwards, however, were not shooting at their best. Our second goal was the result of a fortunate long shot by Cook, which struck the post and rebounded into the net. London forced one or two corners after this, but no scoring resulted.

Remarks.—Rook, in goal, was never hard pressed, but was called upon to save by running out on more than one occasion. All three halves were good, Gibbons doing a deal of useful work. Edmond had a fast outside man to mark, but did his work well. Keer is always in his place to defend. Of the forwards, Edey played a bustling game. Wain improved much in the second half. Jones combined well, but was off his shooting. Cook is fast at outside right, Mitchell had bad luck with a quick shot which turned out off the post.

Team.—H. C. Rook (goal); K. H. Hole, W. Johnson (backs); J. A. Edmond, H. V. Gibbons, H. J. T. Keer (half-backs; W. W. Cook, D. Wain, F. H. Edey, T. L. Jones, D. A. Mitchell (forwards).

GUY'S v. St. THOMAS'S.

Inter-Hospital Cup Tie.—Semi-Final.

Played at Parivale, on the University College ground, on Thursday last. Guy's won by 7 goals to 2. Guy's were at full strength, with the exception of Denning, whose place was taken by Gibbons. Losing the toss Guy's had to play against the wind and uphill. Play was even at the start, when Whiteley got through and opened the score with a good ground shot. On resuming, Thomas's forwards made a determined movement, Wood being called upon to clear. Guy's replied, and Birks made a good opening for Whiteley, who again scored. Thomas's forwards were again dangerous, notably the left wing, but Bastard, at right back, broke up the combination. Play now moved round the Thomas's goal, and Crook, sending in a fast shot, made the score 3—0. Thomas's now made a great effort, the left wing, backed up by Sutcliffe at half (who played throughout a very sound game), brought the ball down to the goal mouth, the inside right beating Wood with a good shot at close range. Shortly afterwards Thomas's scored again, rather luckily, half-time coming shortly after some very fast play, the score being 3—2. On restarting Guy's settled down in a business-like manner, though severely handicapped by Birks, who, just before half-time, ruptured a muscle and was rendered almost useless. The Guy's backs now kept the ball away from their goal, and, giving the forwards numerous openings, Whiteley soon scored with a good screw-shot. From this to end Guy's had all the game. Humm, who worked very hard, scored twice in succession; Crook, at centre-half, was a host in himself; Pedrick, apparently not benefited by his holiday, did not show to advantage. The ground was in a very bad condition, telling upon both teams. We now meet University College in the Final.

Team:—Wood (goal); Mills and Bastard (captain) (backs); Gibbons, Crook, and Pedrick (half-backs); King, Witts, Whiteley, Birks, and Humm (forwards).

Hockey.

GUY'S v. BART.'S.—Final Cup Tie.

This was played at Richmond on the 2nd, and resulted in a win for our XI. by one goal to nil.

The first half of the game was generally slightly in favour of St. Bartholomew's, but the weakness of their forwards, combined with the strong defence of the opposition, prevented their scoring. At half-time neither side had penetrated their opponents' defence.

On changing ends, Bart.'s again assumed the aggressive, but after about ten minutes we got the upper hand, and a good run by A. Birks looked like ending in a goal. H. F. Griffith, the Bart.'s custodian, was equal to the occasion, but he was beaten a minute or two later by a clever shot by C. B. Ticehurst. This proved to be the only goal of the match.

Notice.

GUY S HOSPITAL CHAPEL.—LENT, 1908.

Special Services.

Thursday, March 12th, at 8.15 p.m. —Preacher, the Right Rev. the Lord Bishop of Kingston.

Thursday, March 19th, at 8.15 p.m.—Preacher, the Venerable the Archdeacon of Lewisham.

Thursday, March 26th, at 8.15 p.m.—Preacher, Rev. Alfred Holland, Vicar of S. Agnes, Kennington.

Thursday, April 2nd, at 8.15 p.m.—Preacher, the Venerable the Archdeacon of Southwark.

Thursday, April 9th, at 8.15 p.m.—Preacher, the Rev. W. Faulkner Baily, Vicar of Plumstead.

Holy Week.

Monday, Tuesday and Wednesday. Holy Communion, 7 and 8.45 a.m. Short Service and Sermon, 8.15 p.m. Preacher: Rev. E. A. Edghill, Sub-Warden of the College of S. Saviour.

Thursday.—Holy Communion, 7 and 8.45 a.m. Short Service and Sermon, 8.15 p.m. Preacher: Rev. B. L. Hope, the College of S. Saviour.

Good Friday.—Litany and Meditation, 7 a.m. Mattins and Ante-Communion Service, 9 a.m. Three Hours' Service, 12—3; conducted by the Rev. S. H. Roberts, S. Mary's, Balham.

Easter Day.—Holy Communion, 6, 7 and 8.45 a.m.

The Holy Communion will be celebrated during Lent on Tuesdays, Thursdays and Fridays, at 7 a.m.

Birth.

WAKEFIELD.—On February 10th, at Charlwood, near Horley, the wife of C. F. Wakefield, M.R.C.S. Eng., L.R.C.P. Lond., of a son.

Ed.—L. M.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

March.

Sat. 21. 1st XI. v. 3rd Kent Artillery (Away).
2nd XI. Final Cup Tie.

Mon. 23. 1st Conjoint Examination begins.
1st & 2nd M.B. (Durham) Examination begins.
Prelim. Science (L.D.S.) Examination begins.

Thur. 26. Mr. Golding-Bird's and Sir Alfred Fripp's Take-in commences (Messrs. Cooper and McEvedy).
2nd Conjoint Examination begins.
2nd Test Final L.D.S.
Meeting of projected Golf Club, 12.30.
Meeting of Clubs' Union at 4.15 in Anatomy Theatre.
Lectures cease.

Fri. 27. Winter Session ends.
Finals M.B. and M.D. and M.S. (Durham).

Sat. 28. 2nd XV. v. London Irish "A" (Away).

Mon. 30. 2nd Test Examination Dental Mechanics.

Tues. 31. Final Conjoint Examination begins.

April.

Wed. 1. May Appointment List opens.
D.P.H. (Camb.) begins.
3rd M.B. (Cantab.) Schedules to be presented at Medical Office.

Thur. 2. Mr. Symonds' and Mr. Steward's Take-in commences (Messrs. Munden and Henderson.)

Notice.

STUDENTS' CLUB.

A General Meeting of the Students' Club will be held on Thursday next in the Anatomy Theatre at 4.15. Election of Officers, Report of Catering Committee, and other business.

Passim.

TO-DAY, Sister Clinical, Miss N. Strick, takes her departure from our midst. She is leaving Clinical to take charge of the Institute; so that, though really no longer amongst us, yet she is "of us." Sister Clinical entered the hospital in April, 1885, as a paying Probationer. In 1886 she took charge of the Eye Wards, and held this position till 1888, when she was transferred to Naaman. For a few months in 1900, when the wards changed with surgeons, Sister had charge of Job; since then she has held her present position.

SURELY, this is a record to be proud of, and one that we imagine has seldom been equalled in the nursing annals of the hospital, It is superfluous here to dilate upon Sister's many and well-known characteristics; since 1901, generations of Clinicals have had to work with her, and one and all are in accord in their enthusiastic admiration of her qualities as a Sister and a woman. She is the established authority on all matters relating to nursing, every point in nursing technique is referred to her by students and physicians alike, and the stamp of Sister Clinical's approval is sufficient to mark any detail as the best. Amongst the nurses, Clinical has been the blue ribbon; it is regarded as the ward where one learns the best methods, and where the science of nursing is found in its highest grade. Thousands of patients could vouchsafe as to the high excellence of their

treatment during their sojourn in Miriam or John, and would join, we feel certain, the large circle of her admirers and friends, who wish her every happiness and success in her new sphere.

Miss Oxford, we believe, is not leaving the Institute just yet, as Sister Clinical is about to take a short vacation before assuming her new duties. On the occasion of the last "round," on Wednesday, the present Clinicals showed their appreciation of Sister by presenting her with a cut-glass, silver-mounted rose-bowl.

Well, the Rugby Cup has gone East again! It was a fine fast game on Thursday week, when London recaptured the trophy. The attendance at the match was larger than we have ever seen it, and the interest in the result was widespread, indeed. The usual scenes of enthusiasm, etc., were enacted, and it was not for the lack of loyal supporters that our colours were lowered. These scenes were referred to in the lay journals, and gave the gentleman who writes the *Daily Express* report ample scope to show some ability as a scribbler—an ability which has been utterly lacking in his appreciation of Rugby football this season. A full account of the game appears elsewhere.

We join our wishes with those of the gentleman with the blatant voice and huge megaphone, who, seated on a milk-can, asked the world in general who would win the Cup in 1909, and then, with a voice Tartarean in its intensity, informed the aforesaid world in general, and the Richmond railway porters in particular—Guy's!

The 1st XI. have been more successful. By their substantial victory over University College, they retained the Cup for another year. Likewise, the 2nd XV. have ended a good season by placing the Inter-Hospital trophy to their credit, the fine total amassed against Bart.'s 2nd XV. last Monday being a highly creditable performance.

Perhaps it will not be out of place here to congratulate the various officials and players in our Rugby, Association, and Hockey teams on the success which has attended their efforts during this season. The 1st XV. have sustained an excellent record, and it was unfortunate that the "great match" should have gone against them. Given different conditions, and a fixture rather earlier in the season, the result of the Final might have been different. So far, then, we have won four cups out of five. May the same success follow our Gymnastic, Cricket and Tennis Clubs in the session to follow!

The Annual Dinner of the Debating Society (report elsewhere) was a highly successful and enjoyable function, and much credit is due to the Hon. Secretaries, Messrs. D. Reynolds and Neville Cox, for their powers of organization. Dr. Savage's address was interesting in the extreme. Such a fascinating subject as "Dreams" always attracts, and when delivered in a personal strain its fascination is much enhanced. We hope at a later date to be able to publish a short descriptive paper on the subject of dreams, which we are certain will be read with interest by our readers.

"Ortocure" is going strong, yet we are sure that many of the Staff, Nurses, and Students have not yet added this interesting and clever souvenir to their library. We advise all to inspect copies, which may be seen at the Matron's office, the Wills Library, and the College Lodge, and once having seen it we have little doubt that they will become purchasers. Bear in mind, *inter alia*, that its object is a charitable one.

The Smoking Concert, which we mentioned in our last number was likely to take place, has been postponed. So much has taken place in the Hospital during the past fortnight—cup-ties, dinners and Physical Society's meetings—that it was thought wiser to hold the "Smoker" over until next session. Nevertheless, do not forget it, and when it does take place let it be a huge success.

On the notice-board in the Smoking-room will be found a list upon which men, who are interested in golf, are asked to inscribe their names. It is projected, as will be seen in a

letter from Mr. F. Morres in the correspondence, to hold a meeting for the purpose of forming a Golf Club at the Hospital. London Hospital have already got their club well under weigh, and it promises to be a flourishing enterprise. Therefore, we trust that not only those men who have already put down their names, but also many others, will attend the meeting and give material assistance to what, we feel sure, will be a great success.

We are pleased to see that the balance-sheet of the Christmas Tea Fund shows the substantial credit of £22 11s. 5d. This annual function is one which has always appealed to us; the unlimited joy it gives to so many—and yet all too few—of the little denizens of our district, on that great day of all days, for them, the 25th December, is the sort of thing which is distinctly elevating. For peace of soul—we won't say body, since its incidence is too soon after Christmas dinner—we know no better sight than these five or six hundred hungry kiddies making short work of veritable mountains of bread and butter, cake, etc., and making the very paint on the ceilings of serious, sedate, old Out-patients wrinkle, to the sound of "Zuyder Zee." Therefore, it is distinctly good to hear of such a substantial balance: may it always be thus.

Notice has been received that the examinations, Primary and Final, for the F.R.C.S. diploma will commence on May 7th and 22nd, respectively. Fourteen days' notice of intention to present themselves for these examinations is required from the candidates. The First and Second Professional examinations in the diploma of L.D.S. will take place on May 1st. Three weeks' notice is necessary in the case of these examinations.

A Committee has now been in existence for about two years with a view to establishing an Athletic Union which should have for its aims the running of Annual University Sports and of University teams in Cricket, Football, etc., which will enable London University to stand on the same basis in athletics as the older Universities. This Union has now been formed, notices have been sent out to every College connected with the University, and applications for membership have already been received. When the membership reaches about one hundred it is proposed to hold a General Meeting at some convenient centre (to be announced), when it is hoped that all members and others who are interested will attend. At this meeting the officials of the Union will be formally elected and other business transacted.

Two very successful Sports meetings have already been held, and in regard to the Football and Cricket teams it is necessary that matters should be hurried on as much as possible. Immediately a sufficiently large membership has been obtained, it will be a comparatively easy matter to arrive at some practical means of starting the teams, but until this has been brought about everything will depend on the individual exertions of the college representatives on the committee. It may be added that every care will be taken to consult the interests of the existing Athletic Clubs, such as the United Hospitals and United Engineers, as the object of this Union is to promote the athletic side of the University as a whole.

On another page will be found an account of the Assault-at-Arms held last Wednesday night, in aid of the Funds of the Nurses' Cottage and the Gymnasium. It was highly successful, and reflects great credit on its organiser, Mr. R. G. Oram. This gentleman has worked with a keenness which cannot be over-praised. Every detail was attended to personally, and it must be a matter of self-congratulation to him that his efforts were so fruitful. Through these columns we would like, on behalf of the "Funds" in question, to thank heartily those ladies and gentlemen who so unselfishly devoted themselves to the performance, and who, by their talent, gave all present a very enjoyable evening. To our own men, also, who took part, we may add that a display such as theirs augurs well for our chances in the Inter-Hospital competition.

Debating Society's Annual Dinner.

Dr. Savage's Address.

Dreams.

"For this, be sure, to-night thou shalt have cramps,
Side stitches that shall pen thy breath up;"
* * * *
"I must eat my dinner."

The annual dinner of the above Society was held on Wednesday, 11th inst., in the College dining-hall. The President, Dr. Savage, took the chair at 7.15 p.m., supported by Dr. Fawcett, Dr. Spriggs, Mr. Ormond, Mr. Thompson, and Mr. Mollison. After an excellent dinner had been done full justice to, and the usual loyal toasts drunk, Mr. Mollison briefly proposed the Debating Society, referring to its great utility in bringing together men of all years, and congratulated the Hon. Secretaries on a very successful session.

Mr. D. Reynolds, in replying for the Society, stated that the success was, in no small measure, due to the President and Vice-Presidents, who, at no little inconvenience to themselves, attended the debates and encouraged men by their evident keenness. He gave a brief outline of the ground covered by the Society during the year. He regretted that so few members had spoken on Ladies' night, but credited this to their innate shyness—a shyness, he archly added, which was not evidenced in the wards. Finally, he thanked the committee for the support they had given him and his colleague, Mr. Neville Cox, during the past season.

Mr. Ralph Thompson, in proposing the health of the Chairman, referred to the filip given to the Society by the President and Vice-Presidents, who, at the imminent risk of being precipitated off the shaky platform, or else of being blown into eternity by the fearful draught, which seemed to be an essential at the Society's meetings, not only took the chair, but in every way encouraged the members.

Dr. Savage then replied, and delighted all by his interesting address on "Dreams," from an autobiographical point of view.

THE ADDRESS.

Years ago, I was very much struck with an inscription on a tombstone. It was, "In memory of a dutiful father." I feel somewhat in that position to-night. I have once more been asked to talk about my experiences. It seems to me that my autobiography will soon be exhausted. I have spoken to you of my experiences as a general practitioner, of my experiences in the Law Courts, and now I am asked to tell you of my experiences as a dreamer.

I thought it better to take it along these lines. I am often asked, "What is a dream?" Well, of course, dogs dream, people say. My definition of a dream will not include dogs. A dream, according to Hutchinson, is mental action occurring during sleep, of which we are more or less conscious when we wake. Therefore we have no right to think that the dog who scratches himself in his sleep is conscious of what he has done, when he awakes. Sir Thomas Browne says he believes children begin to dream at the age of one. I have my doubts. My definition is, that dreams correspond to delusions when we are awake. Or, to put it the other way, that dreams are delusions when we are asleep.

Then comes the next question. Why do dreams occur? I have the gift of sleep. I could, for a wager, undertake to go to sleep for one or two minutes and then wake. And on one occasion last summer, after having been fishing, I returned home, threw myself into a chair at 7.25 p.m., and said I would sleep for five minutes. I woke up two minutes later. During that interval I dreamt I had a difference with my son, who said he must have a butler. All that in two minutes.

Dr. Frederick Taylor, another Alpine friend, and myself, started out to climb a mountain from a side which had never been done before. We found it more arduous than we expected, and instead of arriving at our destination at four we did not get there until six o'clock. We were perfectly certain we could not get down that night. Nevertheless, roped together, we descended as far as we could, until we were stopped by a sheer precipice. Here we stopped for the night; I, being the weightiest, was placed on one side of a rock to counterbalance the others. And now I must make a confession. I was the only person who had a flask of brandy. It was very cold; the others were asleep. I began unscrewing the flask, when, suddenly, Dr. Taylor's voice said, "What are you up to?" I hastily replaced the flask in my pocket. The only way I could rest comfortably in this position was by putting my foot up against a ledge of rock. It kept slipping down. Between losing consciousness and my foot slipping down I had a dream. "Oh! dear me, I must go home and dress for dinner." I went home, dressed, and ordered a hansom. I drove to a house and was shown into the drawing-room. My hostess greeted me. "I am afraid I am rather late." She said, "Will you take me down to dinner?" The servant said, "Will you have mulligatawny soup?" All this in that short space.

Varieties of Dreams.

Flying.—One of the most common dreams is that of flying. Some people never dream. I cultivate dreams. Dreams uncover experiences in our past about which we know nothing, subconscious impressions of which we have no knowledge. Flying dreams are said to be associated with our Simian ancestors and their habits. I must have been chased by a megatherum many a time, for I have often experienced those flying dreams.

Inadequate clothing.—There are very few people who have not had that dream. I have it at least once or twice a month. I find myself in a ball-room, and the greater the crowd the fewer clothes I have on. It is a very rare thing for a person to dream that he or she is quite naked. However, I recently dreamt I was. I had challenged a friend to a hundred yards' race, and he had his clothes on; I had not. There was no sense of shame,

but the predominant idea was one of taking a mean advantage of him. Last year I gave the Lumlein lectures, before the College of Physicians. Naturally, I was thinking a good deal about it. The night before the first lecture I dreamt I was in the lecture room before the President. The clock struck one, two, three, four, five. The President said, "It is time you went in." I said, "I cannot go in in combinations." It is a very common dream, indeed, that of being partly naked.

Falling.—This is another common dream. Some people have said that if you dreamt you were falling and you reached the bottom you would be dead.

Catching trains.—Another dream I have once or twice a week. I have got to get to Waterloo Station to catch a train. I ask, "Where is the platform?" They tell me. Can I get to that platform? No, I cannot. I find myself walking to St. Paul's. I get to the station at last. They say, "Get into the train." I say, "No, how can I, with my salmon-rod up?"

Packing.—It is the same with packing. I get a box and put things in, keep putting things in, and there are still more things. I never finish.

Dual personality.—People dream they are two distinct beings. I find myself divided into A and B. A asks B a question, and B says, "Don't you know that?" Then there is the dream of a person seeing himself dead. There was one man who dreamt he was dead and was going to be buried. He objected to the situation chosen; he said it was too damp.

My experience of that kind was still more striking. I had been a sixteen-hours' climb. I got to the hotel. There was no place for me to sleep properly. The room was on the ground floor. There was a small amount of water to wash in. Being very thirsty, I drank the whole of the water. I went to sleep. I was divided into two, A and B. A said, "You are going to be ill." B said, "Nonsense, never felt better in my life." A, "Water on the brain, serous apoplexy." B, "Well, Wilks doesn't believe in that." A, "You are going to be delirious." B, "Then you must send for So-and-So." A, "There is no time; you are going to die." I do die. There is going to be a post-mortem. I solemnly proceeded to take off my calvarium. I woke up with these words, "Well, I'm d——d! There is no brain, it *is* all water." I thought this dream was too good to lose, so I got up to write it out. In the middle of doing so my guide tapped at the window. Seeing I was up, he said we might start, as it was a lovely night. And only two hours' sleep!

Mental faculties in dreams.—One of the most interesting is the question of memory. You have an interesting dream. You try to remember when you wake. You cannot, but during the day you are able to remember it. It is perfectly true that the memory of the dream is very short.

As for your judgment of what is good:—You think your dreams are magnificent. You think they are very fine. Also what you do and what you say. I always think of a friend of mine, who thought he had found a splendid word. He wrote it down, "magnificon." Another instance of what sounded wonderful in a dream was this sentence I once dreamt, and thought worthy of Lewis Carroll, "You may fell the tree, but then it will not make any more butter."

Character in dreams.—One more question. Do our dreams represent our characters? Some have said Yes, your real character is represented in your dreams. There was a certain Eastern ruler who found one of his courtiers looking very gloomy. He asked the reason. "Your highness, I dreamt I had conspired against you." The monarch said nothing, but had his courtier's head off. He thought if he dreamt it, he must have previously thought about it. There is one thing certain about our dreams, that is, there is much, thank goodness, we are not responsible for.

Finding things by dreams.—One of the most interesting subjects is the finding of things in dreams. Take some of those that are well authenticated. Take the case of two men who see some of their cattle destroying the corn. They go after them. On the way they climb over a fence. They come home and go to bed. One says, "My watch has gone. Wonder where I lost it?" They go to bed. In the morning he says, "I am perfectly sure it is hanging on a twig by the paling." He goes and finds it there.

Another case: A man loses a diamond out of his ring while playing tennis. During the night he dreams it had fallen in a certain spot. He looks, and finds it there in the morning.

I was telling this to a lady. She said, "I have done that several times. I once lost my bracelet. I went to bed and dreamt where it was and found it."

It is quite explicable. Take the first case. He is going to drive away the cows. He is intent on this. He gets over the paling; he feels a tug and does not notice it, but it is recorded. During sleep it has been revealed.

Some of Hutchinson's recorded dreams are beyond my comprehension. Some are inexplicable from a medical point of view. It was said that, during the plague, men had a certain kind of dream before the plague seized them. One of interest he gives. A certain lady, the daughter of a hunting man, was very much concerned about her father. He had had fainting fits and nearly fallen from his horse. She dreamt night after night that he fell from his horse and was killed, his dead body lying in a certain spot. She warned him and asked him to give up hunting. He obeyed her for a time. Later on he felt quite fit, and one morning went for a ride. His horse came home without him. She said, "You will find his dead body in such-and-such a place." They did.

Dreams within dreams.—Another point of interest is a dream within a dream. A friend of mine dreamt he was converted into a little girl; the little girl dreamt she was a butterfly; then, again, she dreamt she was changed back into a little girl.

Some dreams have been helpful to me from a medical point of view. Take the case of melancholiacs, for

example. I ask, "Do you dream?" Oh, yes, miserably. Then that patient is not improving. If they say their dreams are cheerful and bright they are improving.

Dr. SPRIGGS briefly replied for the Vice-Presidents. It gave him much pleasure to come back amongst us all again, and he was certain that in very few other hospitals did there exist such an ésprit de corps as at Guy's. He remembered well an incident, which probably had inspired Mr. Thompson's remark on the chairman's perilous position on the platform at debates. He was once in the chair, and after a short speech he had gracefully sat down, when, much to his surprise, and to the general amusement, he found himself in the coal-scuttle. The back legs of the chair had rebelled against the limited space.

Dr. FAWCETT, in a few words, proposed success to our 1st XV., recalling a cup-tie in his fifth year when, after a great game, Guy's had got home by a try.

During the evening many vocal numbers, contributed by members, added much to the enjoyment. Messrs. Humm, Nutman, Adams, Oram, Cooper and Duke, with Mr. K. H. Hole at the piano, giving a programme which was in every way excellent; a measure of their success being the insistent demands for "encores." The pleasant evening ended at 10.15 p.m., the company singing "Auld Lang Syne."

The eighty-sixth meeting of the Society was held in the College Smoking-room on March 14th; Mr. Ormond in the chair. There being no private business, the chairman called on Mr. Sharp to propose "That in the opinion of this House the Surgeon is of more use to the community than the Physician." Mr. Price opposed, and Messrs. Mitchell and Morton-Palmer seconded the proposition and opposition, respectively. Mr. Ormond, in a short speech, threw the subject open to discussion, and there spoke Messrs. Reynolds, Ball, Atkinson, Wood, O'Callaghan, Neville Cox and Thompson. Mr. Ormond then summed up in an excellent speech, and on the motion being put to the House it was lost by two votes. A hearty vote of thanks to Mr. Ormond for taking the chair terminated the proceedings.

Change of Address.

Mr. Harold T. Dear, L.D.S., 40, Wiltshire Road, Brixton, S.W., to Ellerslie, Vernon Road, Sydenham, S.E.

Dr. Thomas E. Holmes, from Rosendal, Redland Road, Bristol, to Portland Lodge, Knighton, Leicester.

Mr. J. McBride, L.D.S., from 145, Finchley Road, N.W., to 26, Duke's Avenue, Muswell Hill, N.

Dr. J. Birch Martin, from Guy's Hospital, to The Beckett Hospital, Barnsley, Yorkshire.

Dr. E. Reynolds Ray, from 15A, Upper Brook Street, W., to 52, Brook Street, W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Dental News.

A MEETING of the Dental Society was held on Wednesday, March 18th, the president, Mr. F. J. Pearce, in the chair. A paper was read by Mr. H. G. Spain on "A Critical Aspect of Modern Dental Education." The writer advocated the inclusion of biology and metallurgy in the Preliminary Science examination, also that dental anatomy should be placed earlier in the course, and made of greater utility to the student. In the final examination the writer pleaded for more practical work, and for courses of useful lectures in such subjects as materia medica, especially from a toxological point of view, and in anæsthetics.

The paper was well written, and in places exceedingly humorous, and an excellent discussion followed, in which Mr. Pearce, Mr. Mollison, and many of the members took part. Among the casual communications were the following:—

A case of Fractured Alveolus caused by a fall. A Fibroma of the Gum. Teeth with large accumulations of tartar. Mr. R. M. King.

Models showing hypertrophy of Maxilliary Tuberosity. Mr. Roberts.

A Sequestrum containing an unerupted tooth, supposed to be caused by an attack of measles. Mr. Holcombe Fuller.

Models showing marked attrition. Models showing rudimentary laterals. Mr. F. N. Doubleday.

Members present, 51.

For the benefit of that unobservant gentleman who, at a recent meeting of the Dental Society, observed that he never saw interesting cases, it may be noted that the following interesting cases are at present to be seen in the Conservation Room:—

Under Mr. LEWIN PAYNE.—Two cases of phyorrea alveolaris which are being treated by the vaccine method. One of these, which has had three injections, is already markedly better. The other has only just come under treatment.

Under Mr. MAGGS.—An interesting case of necrosis caused by alveolar abscess.

It is hoped to fully report these cases later.

As some men do not appear to understand the new appointment open to them as assistant surgeon's dresser, the following note may be of use:—This appointment is for three months, and the duty of a man holding it will be to attend in the Out-Patient department at 9 a.m. two mornings a week for six weeks, and one morning a week for the other six weeks. He will there see accident and casualty cases sent from the Front Surgery, and will treat them under the supervision of the Out-Patient officers. The cases are of many varieties, and include cuts, septic fingers, scalp wounds, septic arms and hands, sprains, bruises and abscesses. The dresser has there-

fore the opportunity of seeing and treating a great number of minor surgical conditions. Further, the treatment often includes the opening of abscesses under anæsthetics.

Dental men will be wise in applying for the post, as the experience gained will be of the greatest value when reading for the final L.D.S. examination

Clothing; its Use and Abuse.

A Meeting of the Physiological Society was held on March 2nd, at which Mr. Ryffel presided.

Mr. G. Marshall read a paper on "Clothing: its Use and Abuse."

A brief abstract.—Earliest man seems to have inhabited a hot climate, and having, for some reason or another, lost the protection provided by Nature, his migration to colder regions necessitated the use of artificial clothing. Two other factors responsible for the assumption of clothing are ornament and morality.

Underclothing should be porous and hygroscopic, whilst it should give the maximum amount of protection for the minimum weight. The main considerations with regard to the material for outer clothing are colour and texture. The most unsatisfactory part of our present-day attire is the conventional foot gear—indeed, it is the only part which commonly produces gross anatomical defects.

In the case of female dress we find that the ornamental factor has greatly outweighed that of animal economy to the detriment of the hygienic value of the clothing. Insufficient attention is paid to that most important branch of this subject, the clothing of children. The abuse of clothing is especially noticed where dress is the means of deliberate alteration of anatomical structure. Here we may include the most serious deformity of all, viz., that produced by wearing corsets, resulting in Glénard's disease, or, as Keith terms it, "corset disease." Although the use of corsets is defended on æsthetic grounds, we should always consider whether our judgment of the beautiful is sound when departing from Nature. However, considerable progress has been made in what Dr. Johnson described as the most hopeless of enterprises —the contest with fashion.

Papers by Guy's Men.

The Effect of Liquid Air on Animal Ferments. By A. Percy Allan, M.D., B.S. Lond.—*The General Practitioner*, 29th February, 1908.

Hypersensitiveness to Antidiphtherial Serum. By W. Bligh, M.D. Lond.—*British Medical Journal*, 29th February, 1908.

On Migraine. By T. H. B. Dobson, M.D. Lond.—*Ibid.*, February 8th, 1908.

A Form of Oral Filter to be worn during Operations by all Persons inside the Operating Room. By Staff-Surgeon G. E. Duncan, R.N. (Illustrated.)—*Ibid.*, 22nd February, 1908.

Assault-at-Arms.

On Thursday evening last, there was held in the Physiological Theatre, in aid of the Nurses' Cottage and the Gymnasium Fund, a Grand Assault-at-Arms. It was given under the auspices of the Boxing, Fencing and Gymnasium Club, and was organised by the energetic Hon. Secretary of that club, Mr. R. G. Oram. The Programme was an excellent one, providing plenty of variety, and one and all of the numerous audience enjoyed it to the utmost.

Amongst others present, we noticed Mr. Lane, accompanied by Mrs. and Miss Lane, and the Matron; Dr. and Mrs. Goodhart, and Mr. and Mrs. Symonds. The Nursing Staff were well represented, and there was a goodly attendance of the Junior Staff and Residents.

The proceedings commenced with a three-round boxing bout between Mr. R. M. King (Guy's), and Mr. J. Pye (Lynn Club). The Guy's man, though giving away weight, showed to advantage. The bout was productive of some smart foot-work on both sides. Mr. Minett, our late Secretary, and Mr. E. Mann, ex-amateur champion, next provided us with some pretty boxing; the old Guy's man seems to lose none of his skill, and both were applauded at the end of the bout.

The next item was a display of foils by Mr. Haycraft (Guy's), and Mr. Dreece (Grave's School of Arms). The preliminaries caused some amusement, one spectator at the end of the Salute asking, from the gallery, "Who won?"

What an ugly looking weapon a nasty naked-looking bayonet is? It is not difficult to understand the effective *morale* which cold steel has in warfare. Corpl.-Major W. Elliot (2nd Life Guards), and Lance-Corpl. Byrne ("Artists"), provided us with an interesting display with these weapons, and a keen fight resulted in a draw, each contestant registering three points. Mr. W. Reynolds then gave a clever display of club swinging. It was a pity that no music was provided for this "turn," as a pianoforte accompaniment does much to make club swinging more interesting to watch, especially to those uninitiated in the difficult exercises which this performer went through. Some amusement was caused by the "gallery," who took "pot-shots" at the club swinger with modest, but none the less solid, pennies. A Sabre v. Sabre contest between Corpl.-Major Eggleton and Corpl.-of-Horse Childs was a very even affair. The conditions were, first three hits to win; the score, after being one all, was two all, and it was only after a good bout of three minutes that Corpl.-Major Eggleton succeeded in registering the final point. During this item, Mr. R. Thompson, who throughout had been a very contiguous and interested spectator in the front row, showed a little uneasiness, and discreetly withdrew to a more distant and a safer position.

The Pavy Gymnasium Class, under their Instructor Staff Sergeant Gilbert, and consisting of Messrs. G. Hunt, J. L. D. Lewis, D. A. Mitchell, W. Reynolds, R.

Montgomery, G. D. Eccles, N. Reader, and R. G. Oram, were very excellent in a display on the parallel bars. In the individual exercises one and all were of a high standard, whilst, may be, special mention should be made of the finished work of Messrs. Hunt and Reynolds. Two well arranged tableaux reflect great credit on Sergt. Gilbert: Mr. Oram in each bore the brunt with the equanimity of a modern Hercules. A Bayonet v. Sabre contest between Corp.-Major Elliot and Lance-Corpl. Byrne was productive of some exciting fighting, and was loudly applauded.

We congratulate the Gym. squad (Messrs. Lewis, Mitchell, Mather, Eccles, W. Reynolds, Watkins, Haycraft, and Montgomery) on their Indian Club Swinging Display. The covering of the clubs with luminous paint, and performing in the dark, was most effective. The time throughout, with an occasional exception, was good. Mrs. Wooding accompanied this "turn" on the piano.

Many of us are familiar with Corpl.-Major Eggleton's sword feats, nevertheless there is a great fascination about this display; the evident skill, together with the fact that there is a certain element of restrained excitement about some of the feats will always render this exhibition popular. He performed the paper cutting and bars of lead act, and the remarkable feat of cutting through a broom-handle suspended from two razors by paper loops, without in any way causing the suspending loops to be disturbed. He next took an apple, which Mr. Symonds, after careful examination, reported to be normal in every way, placed it in a handkerchief and cut the apple in half without damaging its envelope. The modified William Tell act followed, Messrs. Gilbert and Oram holding in the palms of their hands an apple, which Corpl.-Major Eggleton, with the daintiest of touches, proceeded to cut in half. This year no lady, amongst the audience, showed any desire to risk their palmar arches, nor yet to simulate Anne Boleyn, and have an apple, resting on the nape of one's neck, cut in two; this latter feat the Corpl.-Major did with the aid of his assistant.

Perhaps what was the most popular item on the programme now followed—two wrestling bouts in the catch-as-catch-can style, between members of the City of London Police. In the first, P.C. Barrett opposed P.C. Humphries. After some slight manœuvring for holds, Humphries brought his man to the mat with a clever "flying mare." He attempted a half-nelson, which Barrett, by a clever roll, got out of. Barrett now assumed the aggressive, and kept the weightier man engaged on the mat. With a clever arm-lock, he almost succeeded in pinning Humphries down; the latter rolled cleverly, and in turn took the aggressive. At this stage the referee had a narrow escape, Barrett almost "laying him out" with Humphries' feet, as the former brought off a clever body-hold. The sixth minute saw them again feinting for grips; Humphries had his man on the mat. A clever get out of a half-nelson, however, gave Barrett a roll and then a pin-fall in 7 min. 44 sec. The match between Wilson and Martin was not quite so even, the former having the advantage throughout. Wilson took the aggressive from the first, and brought his man smartly down to the mat. Martin evaded a half-nelson, and after some feinting for grips, was again brought down by a clever body-hold. Martin from now on was in difficulties, and his opponent, by an arm-lock, gradually forced his two shoulders back. Time, 6 min. 5 sec.

The next item, an exhibition of Lance, Sword, and Gun drill on the slack wire, by Sergt. Mumford, was very clever and much appreciated. He performed also the difficult task of undressing whilst balancing on one foot on the wire. It is much regretted that Mr. Higgins was unable to appear, but Dr. Allport, another of our ever-popular staunch veterans, made a welcome re-appearance, and in a three round boxing bout with Mr. J. G. Ross, showed that in spite of encroaching years he retains much of that ability which made him quite famous in his year.

The programme concluded with a Vaulting Horse display by the Gym. squad. It was a very finished performance. During the evening Mesdames Oram, Wooding, and Harris, officiated at the piano.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

A Golf Club.

DEAR SIR,—It is proposed to hold a general meeting of those at the hospital who are interested in golf. The meeting will take place on Thursday, March 26th, at 12.30 p.m. Notice of room, etc., will be posted shortly before, but if you will publish this letter more widespread notice will be taken, I hope. At the meeting a proposal will be made to form a Guy's Golf Club, which, if agreed to, officers will be elected, and then the question of finding a links or a club willing to admit Guy's men at a reduced rate will be raised. This is only a rough outline of the purposes of the meeting, and it is to be hope that men will turn up so that the question can be full discussed.—Yours sincerely,

F. MORRES.

Guy's Hospital, March 18th, 1908.

BOOKS, &C., RECEIVED.—Thomson's Heredity; Warwick & Tunstall's First Aid; The Romance of Medicine; Selected Essays on Syphilis and Small-pox (New Sydenham Society's Publications); Fasiculi XXV., XXVI. and XXVII. of the Atlas of Clinical Medicine, Surgery and Pathology; Bulletins et Memoires de la Société des Hôpitaux de Paris; Journal of Pathology and Bacteriology, Nos. 2 and 3, Vol. XII.; The Journal of Obstetrics; Journal of the Royal Army Medical Corps; Medicinsk Revue.

A Case of Jaundice due to Portal Pyaemia.

CLINICAL LECTURE BY Dr. W. HALE WHITE.

December 12th, 1907.

Gentlemen,—The case I propose to take this afternoon is that of a man 18½ years of age, whose history is that on November 15th he was taken with pain in the abdomen. It was so bad that he returned home from his work about noon, feeling very ill. He vomited several times during the afternoon and evening of the 15th, and the pain continued, off and on, during that and the following days. He had one or two attacks daily, was very ill, and at the end of a week was thought to have typhoid fever, because the temperature remained raised for six days. Being certified as having enteric, he was sent to the Brook Hospital. The report says that on admission there were no spots to be seen, and the abdomen appeared normal. Shortly after admission he had a rigor, lasting twenty minutes. The temperature rose from 99·8° to 103° in two hours. On the 21st he was found to be jaundiced, and the urine contained bile. The liver was noticed not to be enlarged; no spots, Widal's reaction negative, and the tongue very dry. When he became jaundiced, he was transferred to Guy's, because clearly he was not a case of enteric. Jaundice is excessively rare in enteric fever; so are repeated chills in the early stage of the case. I saw the patient shortly after admission, and then the state of affairs was, that he lay in bed deeply jaundiced, obviously very ill, rather drowsy. On examining him, we found that the liver came about two fingers' breadths below the ribs. Upwards it was enlarged only in one place, *i.e.*, in the mid-axilliary line. You know that in the nipple line the liver should reach the lower border of the fifth rib, and in the mid-axillary line to the seventh. And on top of the normal liver dulness there was, in the mid-axillary line, a dome-shaped dulness a little larger than a five-shilling piece. We examined his blood, and found that he had just under 5,000,000 red cells and 7,500 whites, and a proportionate diminution of hæmaglobin. The first thing we seized hold of as important was this little area of increased dulness at the upper border of the normal hepatic dulness, because clearly that indicated something added to the top of the liver. It might have been a sub-diaphragmatic abscess—it might have been a swelling of the liver itself. But considering the rigors, we put an aspirating needle in, and drew off some filthy, foul-smelling pus and blood, which contained a streptococcus, Friedlander's bacillus, and other micro-organisms. Sir Alfred Fripp almost directly after made an opening where our needle had been inserted, and let out some filthy material—a mixture of blood, pus, and breaking-down hepatic tissue, which smelt horribly. Next day the patient remained extremely drowsy, and finally he became delirious, and died.

As we stood by the bedside we had to go over in our minds what could possibly be the matter with him. The first question was, why should he be jaundiced? What can be the matter with a man who is jaundiced? In such a case there are two problems: (1) Why has he bile circulating in his blood? (2) What symptoms has he got which are due to bile circulating in the blood?

In regard to the first question, it is important to remember that more than four-fifths of all the people who are jaundiced are jaundiced because there is some gross obstruction to the bile duct; for example, a mass of malignant disease pressing on the common duct. When there is gross obstruction, the bile cannot flow into the intestine. You will remember it is secreted under very low pressure, so that very soon after the bile that cannot get out has collected in the bile ducts, it is absorbed by the lymphatics, passed from them into the blood, and so circulates in the blood-stream. That it goes by the lymphatics has been shown experimentally, because if you obstruct the bile duct in an animal, it does not become jaundiced if the thoracic duct is ligatured. If a case of obstructive jaundice lasts for some time, you are surprised to find, post-mortem, that the ducts contain clear mucus, and not bile, as such cases do earlier. The reason is not difficult: the pressure in the biliary channels becomes so raised, that the bile is reabsorbed almost as soon as it is formed from the very minute biliary channels, so that the larger vessels remain empty, and secrete mucus, such as ordinary mucous membranes do. When the larger channels are full of mucus, if you look carefully you will find that the minute ones contain bile.

I do not know anything that it is more important to discuss with you than the causes of jaundice, because several ingenious books have made up literally scores of causes of jaundice, and yet the ones which occur in actual work are few. In an examination I can often tell whether the man is a practical man, or whether he has merely read his book, by asking him

about jaundice, because sometimes one of the first causes given by a man who has merely read his book is, a round worm crawling up the bile duct. Such a thing has been known to occur, but only very rarely indeed. This reminds me of a candidate whom I examined a few days ago, and whom I asked what were the causes of hæmoptysis, and the first cause he gave was actinomycosis of the lung!

Let us take those causes of obstructive jaundice which are gross and visible to the naked eye in the order of their clinical importance.

There is no doubt that the most common is catarrhal jaundice. This is an inflammation, certainly microbic, which spreads from the duodenum into the biliary passages, and causes a swelling of the mucous membrane, and a secretion of thick mucus, so that the ducts becoming blocked, the patient becomes jaundiced. These cases very rarely die; the patient is not seriously ill, the jaundice shortly passes off. Obviously, as our patient was so very ill, he could not have had catarrhal jaundice, so we can quickly put that out of court.

Perhaps in hospital work the commonest cause of a jaundice due to gross obstruction is malignant disease of the liver. The way that usually operates is as follows:—The patient has malignant deposits in the liver. Secondarily to that, the glands in the portal fissure become infected with malignant disease, and they press upon the bile duct, with the result that there is obstructive jaundice, and bile is absorbed from the ducts. Our patient evidently was not a case in point, for he had been taken too suddenly ill for us to entertain the idea that he had malignant disease.

The next commonest cause of jaundice is gall-stones. When stones obstruct the duct, bile cannot get on; it is reabsorbed, and the patient becomes jaundiced. Our patient gave no history that he had had gall-stones, and uncomplicated gall-stones could not have made him as ill as he was. A complication which he might have had we will discuss shortly.

In hospital practice I think the next most frequent variety of obstructive jaundice is that caused by cirrhosis of the liver. The mechanism there is that the fibrous tissue of the liver, contracting, constricts the minute ducts and obstructs them. There is a good deal of small-celled infiltration of the liver, and that helps to obstruct the ducts. And possibly there is catarrh of the ducts, and that will lead to obstruction. At any rate, there are several ways in which minute ducts can be obstructed in cirrhosis, and the bile will be absorbed. Our patient's liver did not feel like a cirrhotic liver; he had been ill too short a time, and had too high a temperature for cirrhosis. No one dreamt he had cirrhosis of the liver.

The next commonest cause of jaundice is carcinoma of the pancreas. You will remember that the common bile duct goes behind the head of the pancreas, and the head of the pancreas is the part of it most frequently affected by carcinoma. The enlarged carcinomatous head presses on the common duct, and so causes jaundice. I find, on looking through the figures of the hospital, that jaundice is present in from half to two-thirds of all cases of malignant disease of the head of the pancreas. The onset was too sudden in our patient for him to have had this, and he was not wasted. About one-third of the cases of malignant disease at the head of the pancreas have ascites from implication of the portal vein, and our patient had not got that.

Another common cause of obstructive jaundice is passive hyperæmia of the liver, such as you see in mitral stenosis. The hepatic veins are very engorged because of the backward pressure, and become swollen, and it is remarkable that the liver can contain an amount of blood almost equal to its own weight. The result is that the minute bile ducts get compressed by the dilated veins, and that is sufficient to cause obstructive jaundice. Our patient had no mitral constriction, or mitral regurgitation, or disease of lungs, which would have led to this condition of nutmeg liver. And possibly we ought to include as a cause of jaundice a condition about which we know very little, and that is, chronic pancreatitis. How common that is at the bedside we do not yet know, because we are only beginning to learn about it. But our patient was acutely ill, so his jaundice was not due to chronic inflammatory swelling of the head of the pancreas.

Those are all the common causes of jaundice. And when we had rapidly run through these causes we had not found what was the matter with the man, and we did not at this period of the discussion consider the other obstructive causes, because they are so rare.

We next began to think of the causes of jaundice, when there is no visible obstruction to the outflow of bile. But, for the sake of completeness, I ought to mention causes of gross obstruction which are very rare. For instance, abscess of the liver, or hydatid cyst of the liver, might happen to have such a position on the liver that it pressed on the common duct. Other causes which have been found are

carcinoma or cicatrizing ulcer of the duodenum constricting the orifice of the duct, a large tumour, such as a huge gastric carcinoma, or a pancreatic cystic tumour, or a tumour of the hepatic flexure of the colon, or a huge ovarian or uterine tumour, or a gigantic aneurism, or a retroperitoneal tumour, or a suprarenal or renal tumour, or a floating kidney. But they are so rare, and most would have to be so huge in order to compress the duct, that it is not practical medicine to discuss them in connection with our present case until we have examined the causes in which no gross obstruction exists. And it has been said that the bile duct may be kinked in gastroptosis; it may be compressed by a pancreatic calculus, by a gumma of the transverse fissure, by a gumma of the pancreas, by tuberculous glands of the transverse fissure, by adhesions in connection with old gastric ulcer. But there was no evidence of any of these in our patient, and they are too rare for us to spend time on them now. Lastly, there seems no doubt that jaundice is sometimes emotional; people suffering from severe fright have been known to become jaundiced.

In our case, when we made a post-mortem on the man who was deeply jaundiced, there was no gross obstruction, nor did we at the bedside think that it existed. I was taught that the reason for the jaundice in such a case was that the bile was formed in the blood; that the patient had some disease of his blood in virtue of which the bile was formed there instead of in the liver, and hence he was jaundiced. We know now that that is not true, because, to take a good example of jaundice formerly thought to be due to the production of bile in the blood, it has been found that the jaundice due to arsenuretted hydrogen does not occur if the animal to whom it is given has had the liver excised; showing that the liver is essential in the production of jaundice. So when a patient is jaundiced we always have to look for the cause of the jaundice in the liver itself. The way jaundice comes about when there is no obvious obstruction of the bile ducts is this. There is a swelling in the microscopical bile ducts in the liver, in virtue of which the bile cannot get on, and it is reabsorbed; and those cases which used to be called non-obstructive jaundice are instances of obstructive jaundice, the obstruction being in the minute ducts. This swelling has been demonstrated in animals which have been given various poisons which produce jaundice without causing any gross obstruction. And inasmuch as those cases of jaundice closely resemble the condition in the human subject, we assume that in a number of conditions there is catarrh of the very minute ducts, leading to swelling of the mucous membrane, and absorption of bile. But it is a matter of such clinical importance to appreciate the difference between the two varieties of jaundice that it is generally spoken of in this way. When the obstruction is gross and visible, the case is called one of obstructive jaundice; when it is not gross and visible, it is called toxic jaundice, because most, if not all, of the cases in which the jaundice occurs apart from gross obstruction are due to some form of toxæmia, such as occurs with phosphorus poisoning, that from arsenuretted hydrogen, and many bacterial poisons. So, as we found no evidence of gross obstruction, we were driven to assume that our patient had a toxic form of jaundice, that is to say, a swelling of the mucous membrane of his minute ducts, with consequent absorption of bile.

Now what, in clinical medicine, are the causes of this toxic jaundice? The commonest is pyæmia. If a man gets infected with pyæmic micro-organisms, some product is manufactured by them, as a result of which he gets catarrh of his minute ducts, and is liable to get jaundice. We had to think whether our patient had pyæmia. The rigors were very much in favour of it, and so was his severe illness. The fact that the liver was a little enlarged below was in favour of it, though the small enlargement on the top of it was somewhat against it. We could find no cause for his pyæmia resulting in infection through the general circulation. There is, however, a variety of pyæmia called portal pyæmia, and that we had to consider very seriously. What I mean by portal pyæmia is this: that there is, at the periphery of the portal vein, a lesion through which pyæmic micro-organisms can gain access to the blood. They are carried to the liver, where they cause, what I will talk about in a minute, pus in the veins and abscesses in the liver, or, in other words, portal pyæmia; and in a certain number of the cases the acuteness of the inflammation of the liver leads to catarrh of the minute ducts, with the result that the patient becomes jaundiced. We had to think whether our patient had jaundice due to portal pyæmia. There was much to be said in favour of it. The objection we had was that we could not find the local lesion. If we had found during life that our patient had had appendicitis, or an ulcer in the rectum, or some lesion in the periphery of his portal system which could have caused the pyæmia to be distributed to the liver by the portal vein, the diagnosis would have been easy.

Another condition causing jaundice, often of the non-obstructive variety, is cholangitis. When patients have gallstones, they are liable, from the irritation of them, to get inflammation of their bile passages. It may be suppurative, but it need not necessarily be. It may lead to pus in the tubes or in the liver, and abscesses in the liver. Unfortunately for this diagnosis, we could not find out that our man had ever had gallstones; and cholangitis, occurring without the irritation of a previous gallstone, which no doubt produces an ulcer of the wall of the duct, and hence micro-organisms can get a foothold, is very rare, almost unknown.

Rarely, micro-organisms in the general circulation, not getting a foothold from the periphery of the portal vein, or from the bile passages, induce jaundice, because they cause swelling of the mucous membrane of the minute biliary ducts. There was an excellent example in Clinical, under Dr. Newton Pitt, in October—a man who was very ill and deeply jaundiced, with no gross obstruction. All that was found post-mortem to explain the jaundice was that cultivations of the streptococcus longus were obtained from his blood. We must assume that the toxins of these caused swelling of the mucous membrane of the minute biliary ducts. Other examples of jaundice due to a general toxæmia are a rare epidemic disease called Weil's disease, and acute yellow atrophy of the liver. Sometimes the pneumococcus causes it, and it may be associated with pneumonia. It often occurs in relapsing fever; it may occur in malaria, in phosphorus poisoning, and as a result of snake bite. In all those cases there is catarrh of the minute ducts from general toxæmia.

There are a few clinical points worth noticing. When the jaundice is of the toxic variety, it is never as deep as it may be when there is a gross obstruction; it is not of the green colour often seen in the latter, because it does not last long enough. And in the toxic form the fæces often contain bile, the reason being that if the jaundice is caused by a catarrh of the minute ducts, it is not likely that all the ducts will be affected. If only two-thirds of them are affected, there would be enough bile passed to colour the fæces, which, indeed, even sometimes contain an excess of bile. The reason for that is very interesting. Many of these poisons which are able to cause toxic jaundice also have the power of destroying blood-pigment. That destroyed pigment is carried to the liver, and there bile pigment is rapidly formed from it, so that the supply of the possible available material for the production of bile pigment by the liver may be so excessive that although some of the ducts are blocked, nevertheless the total amount of bile in the intestine is in excess, so that the motions are darker than they would be in health. So in toxic jaundice, there are all varieties of colour in the motions.

We rather came to this conclusion, that our patient had some form of portal pyæmia, although we could not find the source. The only thing against it was that the dulness of the liver had that local increase in the mid-axillary line. The importance of that it is difficult to over-estimate. That always ought to make you think of abscess of the liver, subphrenic abscess, or, possibly, local empyæma at the base of the lung. Malignant disease of the liver, and gummatous disease of the liver do not produce a local enlargement upwards. In malignant disease of the liver the great weight of it may drag the liver down; the growth rarely pushes up and grows through the diaphragm. In abscess, and, to a less extent, hydatid, the diaphragm becomes implicated, and the abscess grows upwards and may produce a dome-shaped addition on the top of the hepatic dulness. But, although in our patient this dome-shaped addition, no larger than a five-shilling piece, was a great argument in favour of a local abscess of the liver, yet his general appearance, his extreme illness, and the rapid onset, made us rather incline to the view of portal pyæmia, yet, in the presence of the strong evidence of a local abscess in the upper part of the liver, we were bound to give our patient the benefit of the unlikely chance that he had a solitary abscess of his liver, which might possibly not only have given physical signs at the top of the liver, but have been pressing on the bile duct, and so causing his jaundice. It would have explained his rigors, but it was very unlikely he would have jaundice if he had an abscess on the upper surface of his liver. As I have told you, we inserted an aspirating needle and got off some dirty pus, which was not like the pus of a single abscess of the liver. But we had to give the man the chance, and, accordingly, Sir Alfred Fripp put a drainage tube in, and a foul mixture of blood and pus flowed away, but the man was not benefited by it, and so we inclined to the belief that the original suggestion of portal pyæmia was correct. You may ask, could he have a solitary abscess of the liver, as he had not been out of Europe? A small proportion of such patients have not been out of Europe.

Now with regard to the symptoms caused by the circulation of the bile in the blood. The bilirubin which is absorbed by the lymphatics

from the liver into the blood, stains the conjunctivæ and skin yellow. And remember the most delicate test as to whether a patient is jaundiced is the colour of the conjunctivæ, but they must be stained uniformly yellow all over, for the little pellets of fat at either canthus are yellow in health. Later the bilirubin in the skin is coverted into biloverdin, and that imparts a green tinge. Our patient did not live long enough to experience the itching which bile causes, but this itching may be very intense, and lead to great trouble. As a rule it is not so intense in the toxic cases, because the obstruction is not so great, and there is not so much bile in the blood. The rare skin disease associated with jaundice, called xanthelasma, I cannot talk about now for want of time; it only occurs with chronic jaundice, so our patient did not show it. The books say that the sweat is stained yellow, but that is very exceptional. The axillary glands, as they are so large, are said to be most likely to secrete yellow sweat. The jaundiced urine is usually the cause of the yellow stains you may see on the sheets or the nightshirt, and the urine is coloured because there is bile pigment in the blood. After a few days' jaundice the liver ceases to secrete bile salts, and so you do not find any in the urine.

With regard to the other secretions, the patient gets a bitter taste in his mouth. Our patient was too ill to complain of that. The colour of the motions will vary very much according as to whether or not the obstruction is complete, and they contain an excess of fat, because the absence of bile prevents the absorption of fat. They may have a very disagreeable odour because of the presence of fatty acids in the stools. Patients with jaundice are liable to bleed readily. Minute bleeding, which would not last long enough to be visible to the naked eye in health, becomes visible in jaundice, because the coagulation-time of the blood is delayed. The pulse is liable to become slow, and it became slow in our patient. Towards the end of his life the jaundiced patient became drowsy and occasionally, as was the case with our patient, delirious; bile in the blood is a coma-producing poison. Nearly all fatal cases with jaundice die comatose; very few become delirious—fewer than the books lead you to suppose.

Portal pyæmia was the diagnosis which we favoured. Some books try to draw a distinction between portal pyæmia and suppurative pylephlebitis. A distinction is hardly justified. If a person is infected at the periphery of his portal system by virulent micro-organisms, notably various streptococci, two things may happen to him. He may have pus in his portal vein. The mechanism of that is, that a clot becomes detached from a peripheral branch of the portal vein, where a septic venous thrombosis has been set up by the organism, and it becomes fixed in a central branch of the portal vein; more clot forms around it, and this clotting extends, it may be, into the trunk of the vein; finally the clot suppurates and breaks down. There may be pus in all the hepatic radicles of the portal vein, or there may be a number of minute abscesses scattered in the liver, radiating around the terminations of the portal vein. Or the virulence of the micro-organisms carried to the liver may be so great that a number of foci of necrotic tissue are found post-mortem. That is what was the matter in our case. I show you the liver from our patient, and you can see a great clot projecting from the portal vein. If the patient had lived a little longer, the whole clot would have broken down, and the vein would have been filled with a mass of softened clot and pus. A quantity of septic material had been carried to the liver, and resulting from this, as you can see beautifully, there are a number of necrotic softening foci. These were so plentiful on the right lobe of the liver that they produced a local enlargement of the liver upwards, which is what we found before death. And when we put the needle in we tapped merely a collection of these foci, which formed a swelling which contained necrotic liver tissue, pus and blood. If we had dissected up the radicles of the portal vein at the periphery, the mesentery, and so forth, we should have found pus there too. Also notice he has an acute pleurisy on the right side. That is very common in these cases. The violent inflammatory process in the liver spreads up to the right side of the chest, and causes an acute right pleurisy, and often some suppuration at the base of the right lung, having the form of a number of pyæmic abscesses. Our case also illustrated the cause of the trouble, because on looking at his appendix we found, as I show you, that there had been recent acute inflammation there. I do not think you often see better specimens of that rare disease, portal pyæmia.

In 40 per cent. of the cases of portal pyæmia, the lesion is appendicitis. So frequent is it that French writers have spoken of such a liver as that before you as an "appendix liver."

The next most frequent cause is some cholangitis, due to gallstones. You will remember

that the minute veins from the bile duct pass into the portal vein, so that when the patient has, owing to a stone, an ulcer in his bile ducts, streptococci and other micro-organisms, owing to this, get into the veins of the bile duct, and so to the portal vein; and thus there may be portal pyæmia in association with acute cholangitis.

Other causes of portal pyæmia are, ulcer of the stomach, of the duodenum, of the colon, of the rectum, of the female pelvic organs, suppurating hæmorrhoids, suppurating mesentric glands, abscess of the spleen, abscess of the liver; in fact, any breach of surface at the periphery of the portal system may cause it.

You may very fairly ask, Why, then, do not we all die of it?—because the number of lesions at the periphery is enormous. Nobody has ever explained why portal pyæmia, with its two varieties, suppurative pylephlebitis and multiple abscess in the liver, is so rare. It only occurs once in every thousand post-mortems here at Guy's. I can offer no explanation of its extreme rarity, considering the frequency of lesions at the periphery of the portal vein. Some years ago, there was a patient in the hospital with empyema. It was opened, the patient did badly, and we found portal pyæmia post-mortem. Probably there the lesion at the periphery of the portal vein was so minute that we overlooked it. Some of the micro-organisms coughed up may have been afterwards swallowed. I think we are justified in assuming that that was the way the trouble happened, because in nearly every case of portal pyæmia we can find a lesion at the periphery of the portal vein. If it occurs only once in every thousand post-mortems, and appendix trouble accounts for 40 per cent. of the cases, the other causes must necessarily be excessively rare.

Occasionally in a case of portal pyæmia the liver appears quite healthy post-mortem, and you may say, Why, then, call it portal pyæmia? Because the patient, in some cases, dies so early in the disease that all we find is suppurative pylephlebitis. In other cases the trunk of the portal vein is unaffected, and as in a Museum specimen I show you the liver is full of minute abscesses, both they and the necrotic patches I show you from our patient often have an arborescent arrangement, because of their being dependent upon the intrahepatic branches of the portal vein. The right lobe is affected more than the left; there may be a local swelling there, as in our patient; and I have already mentioned that you may find the diaphragm and right lung affected. There is often peritonitis associated with portal pyæmia, and that is not surprising, because often the appendicitis itself is the cause of the peritonitis.

Very occasionally there may be general pyæmia supervening. And the way that occurs is that one of these necrotic areas, or one of these abscesses, bursts into one of the hepatic veins, and so the material is carried into the general circulation.

Our case illustrates the clinical symptoms of portal pyæmia. Dr. Frederick Taylor, not long ago, published a very good case in point in the Guy's Reports, and he reminded us that you have to think of three things: first of all, the patient has the local disease which is to cause the portal pyæmia, usually appendicitis. In our case there was no swelling or pain, or anything to direct attention to the appendix. The next symptoms that appear are those of the pyæmia. They were shown in our patient by his severe illness, by his rigors, his oscillating temperature and his dry brown tongue; also by his sweating, his rapid, feeble pulse, and his extreme prostration. The third group of symptoms which you find are those which direct attention to the liver. The commonest of those is for the liver to be tender and swollen. Whether or not a patient gets jaundice is an accident; namely, depending on whether the affection of the liver leads to the catarrhal inflammation of his minute bile ducts, so that there is microscopical obstruction of ducts, or what we have called toxic jaundice.

These cases of portal pyæmia are nearly always overlooked clinically, although, happily, we got nearer to the right diagnosis in our case than is usual. And the reason for frequent failure to diagnose portal pyæmia is that very often the primary lesion at the periphery of the portal vein is so acute that, if the patient does not happen to become jaundiced—and only half the cases of portal pyæmia are jaundiced—the symptoms are set down to the primary lesion, and not to the portal pyæmia. Another rarer reason of difficulty is that it is common to get pleurisy and pus on the right side of the chest, and sometimes it is that which attracts attention. There is a complaint of pain on the right side; there are signs in the lungs, the doctor may find pus, and he regards it as a chest case, not one of portal pyæmia.

The outlook is very grave. As far as I know, no treatment does any good. Perhaps some day a serum or vaccine treatment will be successful.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants.—Messrs. C. A. Basker, ~~C. W. Dryland,~~ J. W. Grice, ~~E. B. Hinde,~~ P. S. Price, G. F. Syms.

Dressers in the Throat Department.—Messrs. T. Evans, W. Johnson, M. A. Rahman, A. E. Lees, H. E. Perkins, H. I. Janmahomed.

Assistant Surgeons' Dressers.—Messrs. G. H. Hunt, J. H. Owen (Sir A. Fripp); N. L. M. Reader, F. S. D. Berry (Mr. Steward); H. E. Shepherd, R. P. Ballard, Q. H. Richardson (Mr. Fagge); M. A. E. Duvivier, W. Reynolds, C. Witts (Mr. Rowlands).

Assistant Surgeon's Clerk.—Mr. A. N. Cox (Mr. Fagge).

Medical Ward Clerks.—Messrs. W. S. Kidd, H. Platts, W. L. Hibbert, W. E. Williams, A. Mitchell, C. Weller, W. H. Catto, F. C. Endean, F. S. Adams, G. H. Peall, C. C. Tudge, T. J. Killard-Leavey, H. G. Rice, W. Ledlie, H. L. Attwater, F. D. Saner, H. Gardiner, D. C. Lloyd, J. W. Williams, J. G. Saner, W. T. Chaning Pearce, K. T. Khong.

Surgical Ward Clerks.—Messrs. J. Pryce-Davies, G. B. Cockrem, T. L. Jones, W. E. Fox, F. A. Dick, M. M. Munden, G. Y. Thomson, A. D. Vazquez, J. A. Edmond, R. Montgomery, H. F. Renton, E. A. Penny.

Post-Mortem Clerks.—Messrs. M. M. Cowasjee, J. Walker, C. C. Holman, A. H. G. Burton (April–June); A. A. Greenwood, G. F. Haycraft, J. R. Perdrau, J. Lee Atkinson, R. A. Rankine, H. B. Kent (May 16th—August 15th).

Clerk in the Skin Department.—Mr. G. H. Peall.

Aural Surgeon's Dresser.—Mr. S. J. Darke.

Clerks to Anæsthetists.—Messrs. V. Townrow, R. C. H. Francis, R. A. Rankine, A. H. G. Burton, D. C. Roberts, C. G. Sprague, H. B. Kent, C. M. Plumptre (April); L. W. Evans, R. G. Oram, S. S. Brook, T. N. Wood, A. R. Khalakdina, L. K. Edmeades, A. H. Crook (May); H. Chapple, J. R. Perdrau (June).

Civil.

CROSS, F. G., F.R.C.S. Eng., L.R.C.P. Lond., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Kingston District of the County of Surrey.

MARTIN, J. BIRCH, M.R.C.S. Eng., L.R.C.P. Lond., has been appointed House Surgeon to The Beckett Hospital, Barnsley, Yorks.

THOMAS, FRANK LESLIE, M.B., B.S. Lond., L.R.C.P., M.R.C.S., has been appointed Medical Officer to the Barnstaple Union.

Naval and Military.

Surgeon H. R. H. DENNY, R.N., is promoted to be Staff Surgeon in his Majesty's Fleet.

Fleet Surgeon HORACE B. MARRIOTT, R.N., is appointed to the *Leviathan.*

Surgeon HAROLD G. T. MAJOR, R.N., has been appointed to the *Donegal;* Surgeon AUGUST J. WERNET, R.N., to the *Canopus;* and Surgeon HARRY M. LANGDALE, R.N., to the *Spanker*, temporary.

Lieutenants HERBERT O. M. BEADNELL, R.A.M.C.; ARTHUR W. GATER, R.A.M.C.; and HAROLD C. WINCKWORTH, R.A.M.C., are promoted to the rank of Captain.

Guy's Hospital Reports.

THE Editors have for disposal a number of the older volumes of the Guy's Hospital Reports. These have been made up into sets, each of which, though not absolutely complete, contains between thirty and forty different volumes issued between 1836 and 1898. The earlier volumes are of particular interest, as they contain original papers by Bright upon albuminuria, by Addison, by Hodgkin, and by Sir Astley Cooper.

There are fewer copies to be had of some volumes than of others, so that the number of volumes in a set varies. Each applicant will, however, receive the most complete set available at the time his application is received. The volumes may be seen, by Dr. Pembrey's permission, in the Physiological Laboratory. The charge for a set to subscribers is 25s.; to non-subscribers, 40s., carriage paid.

Applications, which will be dealt with in the order in which they are received, must be accompanied by a remittance, and should be addressed to the Editors, Guy's Hospital Reports, 26, St. Thomas's Street, London Bridge, S.E.

Papers by Guy's Men.

The Erasmus Wilson Lecture on the Pyogenetic Activities of Pneumococcus. By J. W. H. Eyre, M.D., M.S. Durh., D.P.H. Camb.—*The Lancet*, 22nd February, 1908.

Rubella. By E. W. Goodall, M.D. Lond.—*Proceedings of the Royal Society of Medicine*, February, 1908.

The Pathology and Treatment of Chronic Constipation. By Arthur F. Hertz, M.D. Oxon., M.R.C.P. Lond.—*Ibid.*

Rupture of the Genital Canal during Labour. By H. T. Hicks, F.R.C.S. Eng.—*The Practitioner*, February, 1908.

Acidosis in Pregnancy. By J. B. Leathes, M.B. Oxon., F.R.C.S. Eng.—*British Medical Journal*, 29th February, 1908.

A Method of X-ray Examination in Cases of Urinary Calculi. By C. J. Morton, M.D. Edin. (Illustrated.)—*The Lancet*, February 22nd, 1908.

The Indications for Surgical Interference in Acute Abdominal Diseases. By F. J. Steward, M.S. Lond. F.R.C.S. Eng.—*The Clinical Journal*, 26th Feb., 1908

Life in the I.M.S.

BY CAPTAIN WATTS.

Plague Duty.

OCTOBER has come at last, and one wakes at dawn to feel a slight chill in the air, a change not only welcome for itself, but also as an earnest of better things to come. As you lie outside your tent under the mosquito net, you hear the stir and bustle of a new day begin; servants gossiping, horses whinnying for their corn, bells on the bullocks a-tinkling as they go to work, their master following behind with the plough over his shoulder; the fowls perched on the khansamah's charpoy clamour for food, all reckless of their impending fate, the basis of an indifferent curry.

Your early morning tea and toast begins now-a-days to have a certain amount of interest for you, while the sight of a boiled egg no longer gives rise to a sensation of nausea. The bath water is actually *cold*. You dress rapidly to find your horse at the tent door; he, too, feels that the cold weather is coming and is eager for a gallop. To-day you have arranged to visit three or four villages some seven miles off. The Zaildar, a native official, whose duty it is to accompany you, is ready, mounted on his raw-boned screaming stallion, whose bit is a piece of rusty iron, his bridle a piece of cord, and whose saddle is as difficult to get into as it is uncomfortable to remain in.

Away you go at a canter along the loose dusty road with the parched fields on either side in which the crops stand, yellow and withered, for this year the rains have failed,—the autumn crop has perished and, unless the rain falls soon, those of the spring will perish too, and that spells famine in a land where folk live from hand to mouth, and where clubs and old-age pensions have not *yet* arrived.

The hills, where Simla and all its comfort lies, are, though only a score of miles away, hidden in the dust-haze, so that you are denied the pleasure of even seeing from afar the tree-clad heights where the great ones live and have their being.

That group of mango trees with the half-ruined well beneath them means a village, and soon, skirting the filthy scum-topped village pond, where the water buffaloes wallow, we ride up the main street to the Pharamsala, or stranger's house, where the village elders await the arrival of the doctor sahib, who has such extraordinary ideas about the necessity for fresh air, drainage and good water.

As we stop they rise and greet us with a chorus of Salaam Hujoor! Bungee Maharaj! while the lumbardars come forward, each clasping a rupee which they tender for you to touch. You take a seat on a charpoy covered with a shawl of dubious cleanliness, and light a cheroot, while they squat round in a circle, on the fringe of which gather a few shy villagers and their tiny children, girls and boys, suitably clad in—nothing. With a feeling approaching hopelessness you try and drive into the thick Punjabi head that Plague is caused by a small animal, which lives in the flea, which lives in the rat, which lives amongst them, an unwelcome, but an unmolested guest.

It is uphill, often dispiriting work; they deny none of the facts you advance (marvelling the while at your ingenuity), but when you are at the end of your arguments, they are still quite unconvinced.

Some believe that the Sahib carries the Plague in his pocket, ready to deal out to them, while others believe that it is his misplaced zeal in killing all these rats that brings the Plague; they recognise that rats die before Plague, and therefore jump to the conclusion that Plague must follow the death of rats, whatever may be the cause thereof.

Hindoos are often hard to deal with, especially the Bunias—the village bankers and tradesmen—since they regard it as a sin to take life. The Jains go so far as to wear a muslin veil over their mouths, and swab the ground before they tread on it, lest they kill, inadvertently, even the smallest living thing. The Mahomedans often object to the privacy of their houses being disturbed, and owing to their "purdah" system are loth to quit their houses even when Plague is raging.

A stroll through the village reveals filthy narrow lanes, so tortuous that no breath of air can ever reach them or the courts that open off. Dark mud houses, with no windows or other means of light or air to penetrate, in fact, a condition of things that makes one surprised, not that the village should be decimated by Plague, but that the remainder don't die as well.

Did you see that old bearded Sikh draw himself up and salute as we passed? He has been a Sepoy; let's go back and ask him in what regiment. "Ha! Sahib, I served for many years in the 45th Regiment, and now I am an old man; I have retired with the pension the Sirdar allows me—those were great days when we marched to Cabul with Roberts, Sahib Bahadur."

The Sepoy learns from his experience of British officers to respect the Sahib, a respect which is evident now in his manner and bearing as he chats to you. The Sikh is second to none in his loyalty to the British Raj, a very valuable loyalty, it must be, in a race whose priests carry swords!

Having extracted a reluctant promise that they will allow you to lay poisoned baits for rats in their village, that they will evacuate their village when Plague comes, and an admission that inoculation is a wonderful cure, for other people, you rise to depart. You are now asked to take some refreshment, for the honour of the village, but you feel that, even in the humble glass of milk, all sorts of horrors may lurk, so you refuse with a smile, saying that you are not thirsty, which is hardly correct, as nothing would be more welcome than a lemon squash with ice tinkling against the glass.

You will probably have much the same experience in the other villages, and are glad when, with a last salaam, you are off back to camp as fast as you can go, for the sun is getting unpleasantly hot, and there are some nine

miles between you and that apology for a cold drink you will get in camp.

Camp is reached, a drink swallowed, and you catch sight of your English mail waiting for you—a much appreciated sight, as news from home is doubly welcome, seeing that you haven't spoken to a white man for close on a fortnight.

How good that cold bath was! One seems to hiss as one gets in, whilst now you are sufficiently invigorated to face the ordeal of an Indian breakfast of the very worst type, in which fowl, and fowl only, will appear. Breakfast over, one or two neighbouring notabilities appear to pay their respects, and have to be made welcome, whatever your private feelings may be, as they can do much to help you, or the reverse. You must always find out if they are entitled to a chair—this being a great honour, and valued accordingly. Perhaps a pensioned native officer will appear in his regimentals, decked out in his medals, who tenders the hilt of the sword he is still entitled to wear for you to touch; if he is a Sikh you will naturally inquire from him about the prospects of "shikar" in the neighbourhood.

A broken night and an early start produce their effect; an undeniable drowsiness which in the middle of the Indian day falls on everyone and everything.

Four o'clock, and you wake with a thirst, to find tea waiting, and you are as ready for it as you ever were for tea and scones in the College after a long tiring afternoon in the wards or theatres. Another bath and a shave, and then you have to decide how to spend your evening, sitting about being conducive to loneliness and depression. Perhaps you have heard that there are black buck not far away, so off you go with your rifle and an unintelligent native as your guide.

A long tramp over a flat brown plain, studded with thorny keekur trees, and you spot them through your glasses as they lie, reflecting what a good meal they will have in the crops to-night. A long stalk on one's stomach when all sorts of unaccustomed muscles, whose names I have forgotten, are brought into play, and you arrive dusty, perspiring and panting, within range; often at this point you observe to your horror the weary cultivator wending his way homewards, a way which invariably brings him so near the buck that they are up and moving off—a hasty shot, and then, according to your luck, a hit or a miss; the latter means a sad walk home, the former a pleasant vista of venison chops for breakfast, and venison haunch for dinner. If your native is a Mussulman, he rushes forward with a knife to "halal" it, *i.e.*, to cut its throat, murmuring the prescribed prayer; as, if this is not done, no Mussulman will eat it; while if it is done, no Sikh will eat the meat.

Some camps may bring you near the duck and snipe, when, after an evening spent up to your knees in water and mud, to the delight of innumerable hordes of hungry leeches, you will return with enough birds to feed your hungry followers, whilst with you will remain the memory of a sunset sky, and the strings of duck flying into their feeding grounds from the rivers and lakes. Another bath and then dinner, the latter made an ordeal by large numbers of winged pests with unattractive ways, from the morbid insect that drowns himself in your soup to your horror—first cousin surely to the cantharides fly—who settling on your skin, and provoking you to kill him, revenges himself by raising a large blister. They effectually prevent you from getting near enough to the lamp to read, so you light a cheroot and sit out under the mango trees, your thoughts, perhaps, straying back to Guy's and Guy's men, until, with a sigh for the days that are past recall, you rouse yourself and seek shelter under your mosquito net, lulled to sleep by the snarling of pariah dogs, and the unmelodious cries of jackals.

Reviews, etc.

The price of books submitted for review should in every case be stated.

The Pocket Anatomy. Sixth edition. Revised and edited by C. H. Fagge, M.S., F.R.C.S. (Baillière, Tindall & Cox.) 3s. 6d. net.

The "Pocket Gray," which has now reached a sixth edition, will henceforth be known by the more appropriate name of the "Pocket Anatomy." The unenviable eputation attached to the former editions for inaccuracy has, by careful editing, been changed. The book has been brought up to date in all respects. The short, terse descriptions and tabulated lists of relations and branches of the vessels and nerves, will be greatly appreciated by those who have learnt their anatomy from larger books, and are revising the subject before an examination. There is a very full index, which enables the description of any particular structure to be readily found.

Essentials of Cytology. By C. E. Walker. Pp. 139 (Archibald Constable & Co., Ltd.) 7s. 6d. net.

This small volume will serve as an excellent introduction to a subject of enthralling interest. It is well written, admirably got up, and free from typographical errors. There is one small point which, in our opinion, detracts from the merits of an otherwise admirable volume; and that is, references to original papers are not given in the foot-notes in addition to the name of the authority quoted.

The chapters on "heterotype" mitosis are extremely interesting in view of the cancer work of the last three or four years. To the biologist, the chapter entitled, "The Morphological Aspect of the Transmission of Hereditary Characters," will prove most fascinating; indeed, it is in many respects the most interesting chapter in the book. The last chapter on cytological methods is too short. We cordially recommend this book to our read rs.

Aids to Surgery. (Students' Aids Series.) By Joseph Cunning, F.R.C.S. Eng. (Baillière, Tindall & Cox.) Second edition. 4s. net.

That there has been a call for a second edition of this little book demonstrates its popularity. The author has

brought this edition into line with modern progress, whilst the sections on gallstones and the diseases of the pancreas have been re-written.

The arrangement followed is that usually found in the ordinary text-books, starting with inflammation and finishing with diseases of the genito-urinary tract. The style is concise and clear, and no doubt many will find this little "Aids" serviceable, in refreshing their memories before an examination.

Proceedings of the Royal Society of Medicine. Vol. I., No. 4. (Longmans, Green & Co.) 7s. 6d.

The February number of the Proceedings maintains, in arrangement and production, the high standard set up by the former numbers.

In the clinical section, among the interesting cases, is one of polycythæmia with enlarged spleen, but not showing the usual accompanying cyanosis; another of hemihypertrophy, the assymmetry involving the whole of the left side of the patient—a boy aged 4½. This hypertrophy of the whole of one side of the body is a rare condition, only ten cases being reported. The pathology is unknown, but Mr. Lockart Mummery thinks it may be due to maldevelopment of some part of the central nervous system. Mr. Sampson Handley showed a case of complete transverse resection of the pharynx with laryngectomy for a squamous-celled carcinoma of the posterior wall. The technique of this operation makes interesting reading, also the account which Mr. Jocelyn Swan gave of a similar operation he had performed.

Amongst other interesting cases in the dermatological section is one of psoriasis with suppurating lesions, which had been treated by vaccine prepared from a growth of staphylococcus aureus grown from the lesions. The result, as Dr. Galloway points out, is anything but satisfactory.

In the section dealing with electro-therapeutics, the treatment of exophthalmic goitre, sarcoma, &c., by X-rays is discussed by Dr. Bruce. Rubella is dealt with in the epidemiological section by Dr. Goodall, whilst Dr. Corben also discusses its "Identity and Ætiology." As a contribution to current "fever" literature, these papers demand attention.

Dr. Hertz' paper on Constipation, in the medical section, is one that all senior men should peruse with great interest, presenting, as it does, the observations which the author has made in a variety of cases of constipation, in a clear, lucid manner.

In the pathological section, Messrs. Battle & Shattock report a case of diffuse cancellous osteoma of the femur. They have, for the benefit of the Continental readers, summarised the case in Latin—an excellent proceeding. The diagrams in this article are splendid reproductions. In the therapeutical section we would draw our readers' attention to a paper on Arterio Sclerosis, by Dr. W. E. Dixon.

Journals received:—Union Magazine; Medic. Temp. Review; The Hospital; The Clinical Journal; S. A. Medical Record; Middlesex Hospital Journal; Polyclinic; St. Bartholomew's Journal; Durham College of Medicine Gazette; London Hospital Gazette; St. George's Hospital Gazette; New York State Journal of Medicine; Calcutta Medical Journal; St. Thomas's Hospital Gazette; Manchester Medical Students' Gazette; The Prescriber; St. Mary's Hospital Gazette; The Practitioner; Le Mois Medico-Chirurgical; Journal of Balneology and Climatology; West China Missionary News; Bio-Chemical Journal.

Sport.

Rugby Football.

GUY'S v. LONDON.

Final Inter-Hospital Cup Tie.

This match was played at Richmond under ideal conditions, on Thursday, March 12th, before 4,000 spectators. Punctually to time the teams lined out at 3.15, and Saunders kicked off. For the first five minutes our forwards, who started off with great vigour, kept the game close to the London line and pressed strongly, but never looked dangerous. Eventually Lindsay relieved the pressure by good kicks, following which the London forwards took the ball to the other end. A scrum took place nearly on our line, from which Archer and Saunders broke away with the ball at their feet and gained a lot of ground. It was not yet obvious who were going to have command of the scrums, and during these first few minutes a critical silence was observed. Gradually it began to be evident that we could not hope for the ball often, and this proved to be the subsequent truth. Not more than half-a-dozen times did our pack heel cleanly and quickly during the whole game. Saner stopped a London rush by picking up neatly and running into touch; just after this, London were awarded a free kick which was well put into touch. Monteith got away in the subsequent line-out, but was hauled down. The London three-quarters then got going, but a bad pass spoilt it. Just after this Saunders obtained possession and got away with great pace, having only Lindsay to beat. He kicked cleverly across and Digby took the ball at nearly full pace, but Palmer had come back and gave him no chance. Digby's rather weak pass fell on the ground near nobody, and a good chance was lost. Lindsay kicked well up the field, but though unimpeded Duke badly misfielded, and was only able to run into touch. Lindsay attempted to drop a goal from a difficult angle. The next point of importance was a free kick to London for offside, Saner being the offender; in excuse, it must be said that the ball hung badly in the London back line. After each side had gained a mark, Lee was applauded for a very long kick. The play was now confined to the middle of the field for some time, each side in turn gaining ground by kicks, Jones being conspicuous, in this respect, on our side. At length London wheeled a scrum well and dribbled down to our twenty-five line, where Saner picked up cleverly and ran into touch. Saunders again got the ball, but passed forward. After a succession of long kicks, Lee at last found touch. Jones was hurt here, and the game was stopped. He had hardly got up again though, when he found touch by a brilliant hook-kick. Immediately afterwards Jones brought down A. B. Lindsay well. Following this the ball came out to Palmer, who executed a clever dodging run, which bewildered Digby. Groans of disappointment from Guy's supporters received the obvious fact that Palmer is faster than Digby, and he nearly reached

our line before Duke tackled him. Good following-up by Mehaffey resulted in a try terminating this movement, twenty-five minutes after the kick off. After the restart, the game returned to our territory, and the London three-quarters looked dangerous in three rushes, a bad pass by Baines spoiling one excellent opportunity. Touch-in-goal brought relief to us. For the rest of the first half, the game was largely confined to the forwards, and our eight, headed by Saunders, did very well in the loose. A splendid kick by Jones found touch within two yards of the London line. Subsequently Archer charged down a kick by the London full back, and, following up, touched down, but was ordered back for forward, much to everybody's surprise. It is significant that Guy's were given a free-kick immediately afterwards right in front of the London goal, but Lee's attempt went just outside the post. Half-time arrived with this failure, leaving London five points ahead.

The first part of the second half was confined chiefly to the forwards, the ball travelling from one end of the field to the other. Monteith was especially prominent in the London pack with a long dribble, while Saunders and Williams shone on our side. Jones terminated an ugly rush by picking-up smartly. London were now heeling, and from one bout of passing Duke was just in time to pull his man into touch. From a quick pass out from touch, however, Palmer ran over, and the referee allowed a try after consultation with the linesman. From the drop-out Stringer and Jones commenced a bout of passing, and Saner took up the attack by a good dribble from a scrummage. He was, however, not backed up well, and this effort lead to nothing. Lee was next prominent in bringing Lloyd down well, and Stringer made a lot of ground by a long kick. A forward pass spoilt a passing run of the London three-quarters, and just after, Macpherson was just pushed into touch in goal. Stringer soon after saved an almost certain score, when three of the London forwards were on the ball dribbling just close to our line. He picked the ball literally from their feet, and racing round behind our posts at full speed, found touch at the twenty-five line. London were now getting the ball every time, and but for the keen tackling of Jones and Digby would have been very dangerous. Later, Duke made a mark near the half-way line, and the kick which the London full-back made on fielding it, was charged down by Saunders. Lindsay recovered the ball, but was pulled down, and Hoby picked up and scored. Lee missed a rather easy place kick. Guy's now took up the attack and obtained the ball in two successive scrums. The excitement among our supporters was intense. On one occasion the three-quarters got going, and Lee made a beautiful opening; with only Lindsay to get by, he preferred to risk a long pass to Jones, but, unfortunately, the latter just knocked on, and an excellent opportunity was missed. London now worked the game back to half-way, but Duke gained ground wfth a good kick. Saunders headed a great dribble, nearly to the London line, and the excitement grew; but again Guy's were repelled, and Kennedy dribbled towards our line. Duke misfielded badly, but took a flying kick into touch. Duke was now having a lot of work, and, except on this occasion, was doing very well. Our forwards were wheeling well now, and Pritchard obtained the ball and started a movement, his pass to Jones being dropped when a good opening was made. London now had a free kick, but it went wide, and Duke found touch well. From a line-out Monteith broke away, and being well followed up the ball travelled through six pairs of hands before it reached Macpherson, who ran round and scored behind the post. No goal resulted from Palmer's kick, but there was now only eight minutes' play left. During this time the Guy's forwards played up and had the best of the game, but the defence was good. Pritchard made a good kick, and Stringer nearly got away but was tackled. Two more rushes by our third line came to nothing. In the last minute Palmer made a clever dodgy run, and finished up with a good kick into touch, when "No-side" came.

Frankly, our display was disappointing. London were undoubtedly the better side together, but man for man it is hard to discover the superiority. Most of the really brilliant individual efforts were on our side, but all of the good combined ones on theirs. In a word, Guy's played Possible to London's Probable throughout. Duke did many good things, but gave us several frights. Of the three-quarters, Jones was handicapped by his knee, and twice fell helplessly over when running straight; Lee and Digby never understood one another; Stringer played well throughout, and many times averted great danger. Saner played a plucky game behind a losing scrum. Pritchard was disappointing as stand-off half, but this is a difficult and heart-breaking position when it chiefly consists of defence. The forwards were beaten in the tight, but were magnificent in the loose. We have never seen Saunders play better, and Archer, Williams, Mullins, and Hoby deserve special mention of the others. We missed Pinching badly, when we remembered his work in the first game against Bart.'s. Teams:—

GUY'S (holders).—H. L. Duke; L. B. Stringer, H. Lee, J. P. Jones (captain), and W. E. S. Digby; G. B. Pritchard and J. G. Saner; S. McK. Saunders, H. R. Mullins, H. Archer, W. E. Williams, G. R. Hind, A. H. Crook, H. Hoby, and A. Moberley.

LONDON.—E. C. Lindsay; E. G. Macpherson, M. Baines, T. P. Lloyd, and A. C. Palmer; A. B. Lindsay and A. S. Heale; H. G. Monteith, S. R. Harrison, E. MacEwan, W. Kennedy, L. Sharp, G. M. Chapman, W. G. Hodges, and J. Mehaffey.

GUY'S A. v. BART.'S A.

FINAL JUNIOR RUGBY CUP TIE.

Guy's won the toss and immediately pressed; Monaghan ran over from a scrum on tbe Bart.'s goal line and scored; Medlock converted. Play was kept in mid-field for the next ten minutes, when Bennett intercepted a pass and raced up to the full-back, then passed to Covell, who scored behind the posts, Medlock converting. Soon afterwards Bart.'s were penalised, and Medlock

kicked a nice goal. Half-time arrived with Guy's leading by 13 points to nil.

In the second half Guy's scored three more tries through Strannock, Medlock, and Monaghan; Medlock converting twice. Bart.'s broke through and scored under the posts, and converted, Guy's running out winners by 4 goals, 1 penalty goal, 1 try, to 1 goal.

TEAM.—P. E. H. Patey; A. D. Williams, G. Covell, T. Clarke, R. S. de C. Bennett; P. Monaghan, D. Medlock; E. Elliott, D. Stout, L. L. C. Reynolds, F. A. Lowe, D. Strannock, C. Roberts, Sharpe and Glendining.

REMARKS.—After their display against London the game was rather disappointing, though, perhaps, the offside play of the Bart.'s halves prevented the game being opened up. Forward, Roberts was again excellent; the halves were not so good as against London, Medlock especially being below form, though his good kicking was the feature of the game. Our three-quarters, though sound, did not play as in the previous round, and did not stand properly. Patey gave a great display, some of his kicking was quite first-class, but he should get rid of a tendency to wait for the ball.

Association Football.

GUY'S v. UNIVERSITY COLLEGE.

FINAL INTER-HOSPITAL ASSOCIATION CUP.

Played at Chiswick, on Tuesday, March 17th. Before a large crowd and under the most favourable conditions of weather, the two teams met to contest the Cup. The University supporters seemed full of confidence, numbering anything over 300, including four brake loads. *Ten* Guy's men watched the game throughout, Harris the groundman being amongst them. The sun was rather trying, especially at the early part of the game, when the ball was in the air rather more than usual. We had our full team out, Birks having recovered from his recent injury. From the kick-off Guy's settled down in a determined way, playing with that confidence which tells, above all, in a Cup-Tie. The passing was accurate and well timed, men being in the right position at critical moments, giving an exhibition of really correct football. Racing down the wing King centred magnificently. Birks taking it through gave us the first goal five minutes from the start. Guy's again worked clean through the opposing defence, when a foul was given against the University. Whiteley taking the free kick from thirty-five yards sent in a shot such as is rarely seen, swerving into the left-hand top corner of the net like a cannon ball. Guy's now rather disconcerted the opposing team by the tactics of their backs, who repeatedly placed the University forwards offside whenever they made an attacking movement. Continuing to press, King at outside right made some brilliant turns, and from his centres Birks and Whiteley each scored again before half time, Guy's now being 4 goals to 0.

On resuming, we again had the upper hand, King delighting the crowd with his marvellous control of the ball and accurate centreing. Some pretty combination between Birks and Whiteley resulted in the former scoring with an excellent shot, scraping in under the cross-bar. Guy's again took up the pace, and Birks scored again. We were now six goals to the good, and slacked off somewhat, thus giving the appearance that the University were pressing, but they seemed to lack the dash that our team showed, and their efforts always ended rather tamely, when they ought to have been more serious, Wood, in goal, only having one real shot to dispose of. The Guy's backs were kicking very cleanly, and played together well. Crook, at centre-half, was always near the ball with some weight. King and Birks were brilliant throughout, the whole team playing, for once, up to the form they are capable of showing. Guy's thus, for the third time in succession, retain the Cup. We must congratulate our captain, H. Rowse Bastard.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

E. M. H., HUDDERSFIELD.—No tubercle bacilli are detected in this specimem of sputum, which contains but little muco-pus.

T. R. A., CHADWELL HEATH.—This specimen is muco-purulent in character, but no tubercle bacilli are found.

PATHOLOGIST.

Births.

FAGGE.—On 10th February, at 3, Devonshire Place, W., to Mr. and Mrs. C. H. Fagge, a son.

MORTON PALMER.—On Monday, March 9th, at 13, Orchard Gardens, Teignmouth, South Devon, the wife of F. W. Morton Palmer, M.A., M.B., B.C. Cantab., of a son.

STEELE-PERKINS.—On February 28th, at Exeter, the wife of John Shirley Steele-Perkins, B.A., M.B., B.C. Cantab., M.R.C.S. Eng., L.R.C.P. Lond., of a son.

Death.

SWINHOE.—At New Swindon, George Money Swinhoe M.R.C.S. Eng., L.R.C.P. Lond., aged 77.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

IT is always a pleasure to chronicle anything about our much respected and honoured Treasurer, Mr. Cosmo Bonsor. He has become, as it were, an integral part of the Hospital, and any tribute to him all of us take as much pride in as if it were to our own selves. Last week, Mr. Cosmo Bonsor, as a mark of esteem from his colleagues on the Board of Directors of the South Eastern Railway Company, was the recipient of a portrait of himself, painted by Mr. A. S. Cope, A.R.A.

THE final meeting of the Physical Society, held on the 20th ult., was a great success. Dr. Frederick Taylor was in the chair, and there was a good muster of members to welcome our late Senior Physician. The winners of the various prizes presented by the Society were announced. That for the best paper read during the session was divided between Mr. Lee Atkinson (whose paper on "A Theory of Cancer" appeared in the GAZETTE of the 7th March), Mr. Macalister, and Mr. Trethowan. Mr. Goodhart and Mr. C. A. Wood divided the prize for the best exhibition of pathological specimens. Dr. Taylor then announced that, after reading the papers presented for the Treasurer's prize, the subject being the "Diagnosis of Acute Abdominal Conditions," he had found that the one bearing the motto, "Nil desperandum," was, in his opinion, the best. This motto was found to belong to Mr. R. G. Chase, so accordingly the chairman called upon him to read his paper.

WE congratulate this gentleman on what, considering the tremendous compass included in such a subject, was a very lucid and comprehensive paper. The discussion which followed was, of necessity, limited in character, many members giving more or less isolated cases, and this discussion only served to make more apparent the amount of labour which had to be expended in encompassing, in such a small space, a subject, the range of which was so great. We hope to have the opportunity of reproducing shortly, in the GAZETTE, Mr. Chase's paper.

WELL done, the 2nd XI. ! who, by beating St. Thomas's 2nd XI., have recaptured the Inter-Hospital Junior Association Trophy, and so added another victory to this season's list. Whilst on the subject of football, we wish *bon voyage* and an enjoyable time to the four Guy's men who are accompanying the British Rugby Team to the Antipodes, Messrs. McEvedy, J. P. Jones, Archer and Hind. That they will render a good account of themselves we have no doubt, and the team as a whole is a useful one, which will, perhaps, avenge some of the defeats which the All Blacks inflicted on the English sides in 1905–06. Mr. Crook was also asked to accompany the team, but was unable to accept. Mr. McEvedy has promised to write to the GAZETTE during the tour, and we are certain his letters will be looked forward to with interest.

THE sets of Reports, which are announced for sale on another page, are selling well. We

would like to point out that, to Guy's men these Reports should be of no little interest. Apart from their intrinsic value as literature, their historical side is one which should attract. The price is indeed a nominal one, and we are certain that those who buy will in no way be dissatisfied with their purchase.

The Annual Meeting of the Athletic Club was held on the 27th ult., Mr. Clement Lucas in the chair. The chief object of the meeting was the election of a new President, Mr. Lucas having resigned after a spell of office in which he has done a great deal for the Club. The great interest he has always displayed has stimulated one and all to do their utmost, and it is with great regret that the Club loses his services. Dr. Fawcett was elected, unanimously, as the new President. The other officers elected were: Honorary Secretaries, S. H. Browning and R. G. Oram; 1st year, G. D. Eccles and S. Reader; 2nd year, N. E. Farr and H. Mather; 3rd year, L. B. King and R. M. King; 4th year, Pryce-Davies and E. R. Stone; Seniors, W. Cook, P. Patey and R. Rankine. It is hoped that all the athletes amongst us will do their utmost to become quite fit, as we are anxious to see the Shield in the Smoking-room again.

We congratulate the following gentlemen on their success in the various prizes:—The Golding-Bird Medal and Scholarship has gone to Mr. H. Stott, whilst Mr. Lucey has been awarded the Certificate. The Junior Proficiency Prizes have been awarded as follows: Mr. F. Cook, £20; Mr. E. Schlesinger, £15; Mr. A. H. Gool, £10; Mr. Hopkins, Certificate. Mr. F. Cook also captured the Woolridge Memorial Prize, whilst the Michael Harris Prize for Anatomy has been won by Mr. Schlesinger.

The newly-appointed House-Surgeons are Messrs. N. Flower and G. F. Stebbing, who are on for Mr. Golding-Bird and Mr. Symonds respectively. Mr. P. Munden, who was appointed House-Surgeon to Mr. Symonds, had, owing to private affairs, to resign, and is taking his leave of us this month. Mr. Stebbing, quite recovered from his attack of diphtheria, takes on his duties. Sir Cooper Perry's new House-Physician is Mr. J. N. Watson, whilst Mr. M. M. Earle is on for Dr. Hale White.

To Messrs. Cooper and Macalister, and the other off-going Residents, Messrs. Smith, Ticehurst, and Nutman, we extend all our best wishes for much happiness and great success in their new spheres. During Mr. Cooper's rule we have had the most successful Residents' dance in the annals of the hospital; this success was alone due to the untiring efforts of our popular ex-President and his colleagues, and in the days to come, when the annual dance will develop into a "minor" social function of no small importance, it will be remembered that the precedent was set up under Mr. Cooper's régime.

The going-off Dinner, held on Tuesday evening last, was a very jolly affair. An excellent menu being done full justice to, the election of President and Vice-President of the Residents for the ensuing three months was proceeded with. Mr. Goodhart was elected President, and Mr. Rippmann, Vice. An innovation we were pleased to see was the presence of the Dental House-Surgeons, and are certain that on all future occasions they will be welcome. The customary speeches, some songs, and an enjoyable evening, ended with Auld Lang Syne.

Our readers will be pleased to hear that Mr. R. P. Rowlands, who has been suffering from pneumonia following influenza, is making satisfactory progress. We trust that his convalescence will be rapid and that he will soon be back amongst us. Dr. Horrocks is, we are pleased to say, now enjoying good health, and is, we believe, resuming his duties next month.

From time to time we receive belated articles from old Guy's men telling us of interesting cases, but their contributions are too few and far between. Most men in practice must at some time have come across cases which, though not quite unique, are yet of sufficient interest to warrant publication. Doubtlessly, many have kept records of such cases, and,

though they may have meditated publishing them, modesty or lack of time has prevented them sending these records to the bigger medical journals. We contemplate publishing, shortly, some such interesting cases which we have received, and assure all old Guy's men that, at all times, we will be pleased to receive their contributions.

An Extraordinary General Meeting of the Rifle Association was held in the No. 1 Physiology Class Room on Thursday, March 26th, at 3.45 p.m. Sir Alfred Fripp kindly took the chair. The purpose of the meeting was to receive the report of the sub-committee appointed to consider the Miniature Rifle Range Scheme. The minutes of the last General Meeting having been read and signed, the Chairman called upon Mr. Henderson to read the report of the sub-committee. This was as follows:—The sub-committee was elected for the purpose of finding out three things:—1. To draw up plans for a site at Honor Oak Park. 2. To find out the necessary procedure as regards local authorities, etc. 3. To find out, if possible, to what extent the range would be patronised, through the medium of the Gazette.

Mr. Oram went to much trouble to draw up plans for a range on the Clubs' Union ground. Two sites were possible, the first against the terrace, and the second on the side of the long ditch at the bottom of the ground. The committee decided that the former site would probably disfigure the ground, whereas the latter was excellent from all points of view, chief amongst which, were the facts that the conformation of the bank adjoining the ditch provided a natural stop butt, and the ease with which a safe range could be erected. As regards the second point, the necessary procedure was that our plans should be handed through the Hon. Sec. of the Clubs' Union to the Clubs' Union architect, who would draw them to scale and submit them to the Borough Council architect for approval of the said Council. The letter to the Gazette, inviting opinions as to the amount of patronage the range would receive, met with absolutely no reply. The committee therefore decided that a large outlay would not be justified.

A suggestion was kindly made by Dr. Stanley Turner, which the sub-committee heartily approved of, that a Miniature Rifle Club be formed first, with rifles, and that a range should be rented for one night (or more) a week, and then, if the club should flourish, this scheme for our own miniature range should be again approached at some future date.

The sub-committee therefore suggest that the present scheme be shelved, and that a Miniature Rifle Club be formed, with a membership subscription of not exceeding 5/- per annum; that its officers be elected separately from the G.H.R.A. officers; and that, should the club be a success at the end of one season, it should become affiliated to the Clubs' Union.

The Chairman, in remarking on the report, and submitting it to the meeting for approval, emphasised the fact of the lack of support, and suggested that, before even so modified a scheme were adopted, it would be wise to ascertain to what extent the men would enter into it. The Hon. Sec. then proposed that a sub-committee be re-elected for the purpose of ascertaining whether a sufficient number of men could be found to form the club and start it on a firm basis. Mr. Henderson seconded the proposal. The following sub-committee was then elected: Messrs. R. G. Oram, H. J. Henderson, G. A. Blake, and G. B. H. Jones, with the power to co-opt a fifth member from among the first year's men. The proceedings terminated with a vote of thanks to Sir Alfred Fripp for so kindly taking the chair.

It is to be hoped, then, that the necessary promise of support will be forthcoming; we are certain that the scheme will be a popular one; all that is required is that men should take steps to assure those responsible for it that their labours have not been in vain. Members of the Committee will be pleased to receive the names of those who intend to avail themselves of an opportunity of so doing.

A Case of Strangulated Inguinal Hernia in a Baby Fourteen Months Old.

By Dr. F. M. Walker.

In passing a cottage in a neighbouring village, I was called in to see a baby that was ill. I had attended the mother at her confinement, and at birth the child was quite perfect. About five months later I was again called in to see the child, as a swelling had appeared in the right inguinal region. I found a small hernia, and a truss was fitted which kept the gut back well. On January 1st of this year, the child had a late action of the bowels, the second that day, after the mother had removed the truss, which she did not replace when putting the child to bed.

During the night the child was very restless and fretful, and vomited twice. In the morning the mother noticed that the rupture was down and looked larger than usual, but there had been no further vomiting, though the child was still fretful. She tried to get the rupture back, but could not. I was simply called in because the mother happened to see me pass, not because the child was ill. When I saw the child it was lying quietly in its cradle, and was not apparently suffering any pain. On examination the hernial swelling was not large; to the touch it was quite soft and easily moveable, but I could not get it back. This was at 1 p.m. I had no chloroform with me, and was some miles from home, so could not try reducing under an anæsthetic. The child cried a great deal when the manipulation was going on, though no force was used at all. I saw the vomited matter of the previous night, but it simply consisted of curdled milk and a little mucus. But there had been no vomiting for fourteen hours, and I could feel no impulse in the hernia, when the child was crying. I felt pretty certain that there was strangulation, though the symptoms, beyond absence of impulse, were not very conclusive. I advised the parents to take the child at once to the Banbury Hospital. Thanks to Dr. Faulkner, under whom the child went in, I am permitted to give the following facts:—At first reduction under an anæsthetic was tried, but without result, and as the child seemed in a fairly good state, it was determined to operate at once. Still there had been no further vomiting. When the sac was opened, it was found to contain the last portion of the ileum and the vermiform appendix, the latter being absolutely erectile from œdema. As the child showed signs of collapsing, the operation had to be hurried through as quickly as possible, so the appendix was not removed. It is very probable that the condition of the appendix was the primary cause of our not being able to reduce the hernia. The child eventually did well, though unfortunately a deep stitch has apparently given way, causing a slight bulging at the internal ring.

The main points of interest in the case are, I think, the very unusual age for a strangulated hernia to be seen; the contents of the sac; and the complete absence of any vomiting at so many hours after strangulation had started, for collapse was setting in when I first saw the child at 1 o'clock.

Guy's Physiological Society.

The Second Annual Dinner was held on March 19th, in the College Reading Room. Dr. Pembrey presided. About 46 were present—not as large a gathering as might have been anticipated, possibly on account of under-advertisement, owing to the success of the first dinner. Nevertheless, as before, the dinner was a thoroughly enjoyable affair, and anything but a failure. After an excellent dinner provided by the caterer, enlivened with snails and horseflesh—which, we understand, physiologists are wont to consume in large quantities—followed the usual speeches and songs.

The programme was as follows:—"The King"; song, Mr. Duvivier; "The Society," Dr. Forsyth; reply, the Secretary (Mr Cook); song, Mr. Warner; "The President," Dr. Cameron; song, Mr. Matthews; reply, Dr. Pembrey; pianoforte solo, Mr. Mackenzie; "The Vice-Presidents," Mr. Turner; song, Mr. Mitchell; reply, Mr. Ryffel; song, Mr. Allen; "The Committee," Mr. Marshall: song, Mr. Warner; reply, the Committee. Auld Lang Syne. Messrs. Mackenzie and Delmege kindly accompanied the songs.

The Psychic Aspect of Secretion.

On March 16th, Mr. H. P. Warner read a paper before a meeting at which Dr. Pembrey presided. The subject of the paper was "The Effect of Mental Processes on Secretory and other Physiological Functions."

The psychical factor is of considerable importance in influencing the flow of secretions into the alimentary canal; every digestive juice is affected directly or indirectly by this influence. Possibly dyspepsia is frequently a result of the absence of a healthy psychical secretion. Moreover, apart from this question of secretions, the physical activities of the digestive organs show in many cases marked subjection to the emotions.

The secretion of urine shows the influence of mental processes in two ways; there is an effect on the actual renal secretion, and also on the emptying of the bladder.

Starling claims to have discovered a hormone which determines mammary secretions; but, although experimental evidence is not conclusive, it is probable, on *à priori* grounds, that in addition the nervous system directly affects this secretion. As may be commonly observed, the circulation of blood is very susceptible to mental influences; it may be affected either by changes

in the rapidity and power of the heart beat, or by contraction and dilatation of the arterioles.

There are other physiological functions, possibly of less importance, but none the less interesting, which may be considered in the same connection. Thus, whitening of the hair, vomiting, the functions of the lachrymal and sweat glands, are in all probability subject to the emotions to a certain extent, whilst it has been suggested —although the evidence is rather rocky—that the mind of a mother may exert a material influence on her unborn child.

Dental News.

We are pleased to congratulate Mr. Kenneth Goadby on his appointment as honorary corresponding member of the Stomatological Society of Hungary.

We are glad to see Mr. Chapman among us again, and all hope that after his run of bad luck he will have a long period of good health and happiness to make up for it.

The examination for the Smith-Turner Exhibition in Dental Mechanics takes place on Wednesday next, April 8th, at the Royal Dental Hospital, Leicester Square. We have four of our men—Messrs. Tibbalds, Tomes, Thornton and Schaefer—entered for the exam., and we wish them every success.

It is hoped that dental men who are keen on golf—and there are many such—will support the proposed Guy's Golf Club. Mr. Gibbons is our representative on the committee, and will be pleased to supply information to intending members.

An interesting case of fractured mandible is being treated by Mr. Spain. The patient, a small boy æt. 6, fell and had his head crushed by a wheelbarrow, the mandible fracturing completely through the symphysis. The patient was seen within two hours of the accident, impressions were obtained, the displacement corrected, and a four-tailed bandage applied. Within twenty-four hours a metal Gunning splint was made and inserted, a four-tailed bandage being again used, and a mouth-wash, chinosol (1–1000), being prescribed. All the necessary manipulation was done without any anæsthetic, and the child is going on well, his only complaint being that he cannot eat enough.

Mr. Badcock's inaugural address to the British Society of Orthodontia is published in the current issue of the "Dental Record," and may be seen in the Wills Library.

There is a vacant appointment as Consulting Dental Surgeon to the Sidcup Cottage Hospital.

How Westminster Beat Guy's: A Romance of 1960.

BY AITCHGEE WAILS.

(From *The Westminster Hospital Gazette.*)

March, 1960, came in like a lion and went out like a megatherium. Ever since the Gulf Stream had been diverted, ten years before, by the "Germless Steamtrip Co.," in order to form the foundation for a sterile track across the Atlantic, the meteorological conditions had become more and more appalling. Earthquakes happened with alarming frequency, and winds, like steadily advancing brick walls, were continuous. The latter were never gusty, so that buildings were comparatively safe, but progress against them had for some time been rendered impossible. The *Express Mail* asked, "Will the wind continue to blow?" and traffic was at a standstill. Nevertheless, the great British Public gradually adapted itself to the altered conditions, and an earthquake came to be looked upon as a useful corrective to the ills attendant on sedentary occupations, unless the fissures in the ground became large enough to engulf an occasional wayfarer, when "Paterfamilias" and "Indignant Ratepayer" wrote diatribes againt the L.C.C. to the farthing Press.

As to the problem of ambulation, everybody now knows how Professor Sale Barker put his finger on the solution a year or two before finding his last resting-place in the Crooke's corner of Westminster Abbey, "His finger," we say advisedly, for all digits save one had been sacrficed to the advancement of the great work cradled by Röntgen—an individual handicap which proved a nation's blessing, as the curtailment of manual possibilities led to the concentration of that mighty intellect on the successful evolution of the Y-knot ether-splitting waves.

Armed with one of these, the pedestrian could, and did, walk in comfort with an artificial vacuum constantly in front of him. It is true that the Labour Government of 1940 prohibited anyone with an income of over £1,000 a year from carrying a Y-knot chest-protector in person, and obliged him to have three members of the unemployed to precede him with them; but the Law fell into disuse when the Suffragette Government, brought in by the inevitable reaction, insisted that these should be first sterilized.

Reverting from these historical details to the incidents with which we are more particularly concerned, 1960 found the students of Westmin-

ster Hospital reduced to a single individual. This had naturally happened from the tendency of the men to follow those who taught them their earlier subjects; but the gallant exceptions proved themselves worthy of the old traditions, and a Cup Tie team (certainly ever-limiting in numbers) had always turned out to do battle on the field, on which Y-knot chest-protectors were barred.

The sole survivor, a Eurasian named Carruthers, whose grandfather had played for the 'Spital in times past, and, according to his own accounts, always scored at least three times, was determined that this sporting custom should be continued, and accordingly prepared to turn out—alone—against the pick of Guys' four thousand students. Obtaining permission from his numerous chiefs was a task requiring tact, but, nevertheless, was successfully accomplished. The Senior Physician, Arthur Davies, M.D., was inclined to demur at first.

"Come, I say, you know, haven't you been having a lot of days off lately?" said he. But Carruthers' persuasive powers soon prevailed. Gerrard Carr, F.R.C.S., Senior Surgeon, grasped the position more quickly. "You know, my boy, you can always trust yer uncle to play the game!" was his remark. While the genial Obstetrician, Hugh Galloway, exclaimed at once: "Let you off? Of course—in three different positions."

The game was to be played, as it had been for generations, in the Little Dear Park at Richmond, a battle-ground which had derived its name from the feminine hockey teams disporting thereon. By some happy chance, seismic disturbances had hitherto left this classic enclosure intact, and, surrounded as it was with Lloyd's Tornado-turning Translucent-sided Tenting, the spectators could watch the game in comfort, although the arena itself remained, of course, blizzard-swept.

Within the sheltered ellipse, the roar of "Guy's!" from thousands of throats was supplemented by gramophones shouting encouragement from records made by Teddy Morgan and other athletic heroes of Early Edwardian times. The supporters of Westminster could be counted on the fingers of one hand. Peering through his gold-rimmed periscope, with one still firm hand grasping the steering-wheel of his motor bath-chair, Sir Rock Carling was holding converse with a bent, bald-headed form, at once recognizable as that of Baron Macnamara. A curious figure approached. It was that of Terry, the football poet. He was dressed in a frock-coat and a football jersey, with an obvious grey wig; and his eyes, set in the midst of a face seamed with countless lines, twinkled at the scene through a pair of glasses supported on a broad black, white and grey ribbon. His bearing, despite a jaunty effort at youth, was that of a man who had passed the "allotted span," and joined the board after allotment. Educated for medicine, he had been a conspicuous failure in that sphere, and had since earned a precarious living at the expense of the football crowds, who generously rewarded his feeble witticisms.

"Ah, Terry," said Sir Rock Carling, "you find this better than medicine, eh?"

"Yes, sir," he replied. "The public don't like the *locum tenens* as much as the locum edian."

"And how do you like the weather?"

"It ought to suit *you*, Sir Rock; it's a regular sirrocko."

Further efforts were drowned in the yell which went up as the Guy's men took their places, bending slightly forward against the wind, which seemed to be even increasing in violence, and, contrary to its usual custom, becoming rather gusty. A roll of thunder muttered in the distance, and the atmosphere took on a curious yellowish tinge. The Westminster unit made a forlorn, pathetic, but determined figure in the other half of the field. With a good-natured smile, the gigantic leader of the Guy's pack kicked off straight to his adversary. As he kicked, an extra gust of wind made him stagger, and the ball merely rolled over once or twice. Carruthers pounced upon it, picked it up, and took a desperate drop. Up in the air went the ball, and the wind, blowing with redoubled violence, whirled it on and on, straight down the field, accurately over the bar and between the Guy's posts, and out of view. A momentary silence ensued, followed by a hurricane of applause as the sporting spectators realized that Westminster had scored. A new ball was brought, placed in mid-field, and—remained there. Try as they would, Guy's could make no headway against the relentless element, though they took good care that Carruthers got no second chance of handling the leather. Disconcerted at first, they regained their equanimity when they realized that after half-time matters would be entirely in their own hands.

Half-time arrived.

The distant thunder had by this time worked up, and crash after crash pealed out overhead. The yellow sky had deepened to orange, and the air was stifling and oppressive. A flake or two of snow fell. The teams lined up again, and Carruthers was observed to sway slightly as he

stood. Half the spectators attributed this to the wind, the other half to refreshments. Events showed both were wrong. Carruthers kicked the ball off carelessly; a Guy's man picked it up, and his fellows formed round him. Carruthers ran down to his own goal with a vague idea of doing something desperate when they arrived. Ball in the centre, the Guy's pack prepared for their onslaught, and started to run, or rather be propelled, down the field. There was a louder crash of thunder above, an answering subterranean rumble below, a large split opened in the ground, and—Carruthers found himself alone on the field.

* * * *

Extract from the *Midnight Sportsman*, March 16, 1960: "Owing to an interruption in the etherographic communications, we are unable to publish full details of the final for the Inter-Hospital Cup, Westminster *v.* Guy's. The only facts that have come to hand are that Westminster were victorious by a dropped goal to nil, and that none of the Guy's men were able to return to their homes. A certain amount of rough play is inseparable from a Hospital tie, but we must strongly protest against the barbarity revealed in this outline, and the methods of Westminster will meet with nothing but condemnation from all right-minded sportsmen."

Charles St. Leger.

An Exam. in China.

On July 7th, the Police Department of Chentu held an examination for doctors practising in this city. Any medical man might be a candidate, whether residing in the city or in the country. Before the date set, over 600 men had signified their intention to be examined, by registering at the places provided. These were divided into two lots, who were given different examination papers. Each paper contained six questions, of which the candidate was permitted to select any two. A translation of some of the questions is given below:—

1. Discuss the diseases peculiar to the three superior and the three inferior "powers" (in nature).

2. Among the seven diseases resulting from catching cold, there are those whose pulse varies in character from the ordinary pulse of this class. How are these distinguished?

3. Carbuncles and allied diseases were strictly classified by Djung Gin (who lived in the 5th century) into lung carbuncles and intestinal carbuncles. These matters may be studied in the Linshu (text-book). Explain in general terms to what organ, and to what pulse-channel, belong the theory, symptoms, and pulse of carbuncles.

4. Heart, small intestines, liver, and kidneys, all have diseases which require purging. Some of these diseases are above the stomach and large intestine; some pass through these viscera; others again do not enter them. Give a detailed explanation of these doctrines.

5. Most cases of malaria are treated through the gall-bladder pulse-channel. Why must the fever be treated differently according to the season of the year? Discuss this question.

6. Wry-necks are either very stiff or moderately stiff. This disease arises from maltreatment of one of the pulse-channels. Which one?

A total of 397 candidates passed this examination, and were accordingly licensed to practise in Chentu and suburbs. A day was appointed upon which all the successful ones met together and received each man his certificate.

A rough translation of the answer to one of the above questions taken from the paper of a successful candidate, may not be uninteresting. One of the questions he chose was No. 5 above. He proceeds:—"The four seasons all have their noxious vapours, and the five viscera are all affected thereby. The fever and the rigors (of malaria) are due to the weakness of the stomach, with interrupted and inefficient digestion. On examination of the text-books on Materia Medica, we find that many of them treat malaria through the gall-bladder. But should one prescribe from a wrong class of remedies for correcting the digestion, or proceed to repeatedly strengthen the spleen, then he will find himself very much mistaken! The true method for curing this disease is nothing more nor less than the making of a clear opening through the alimentary canal. If we would know the causes of this class of diseases, we must remember the principles of hygiene. An examination of the long-established treatises, together with the famous prescriptions, shows that there are methods whereby the diagnosis, the theories of the disease, and the treatment, may be determined. Nine attempts and we shall arrive at the truth! (a quotation). How shall we endeavour to preserve life? The principles of hygiene are real! When food and drink are taken in harmony with the needs of the system, how then can these pestilential diseases find an entrance."

Here we have, then, ample evidence of the grossest ignorance of the very foundation principles of medical science. Anatomy and physiology are unexplored territory, Materia Medica consists very largely of a long list of prescriptions, with the diseases for which they have been found useful. Intelligent medicine and surgery are practically impossible, because intelligent diagnosis is impossible. For this in turn must depend upon a knowledge of the structure of the human body, and of the functions of its various organs. Other important and indispensable branches of medicine are either entirely unknown or ignored. Finally, to cap the climax, we are treated to the spectacle of the more than six hundred members of the medical profession of this city submitting to an examination on the technicalities of their specialty at the hands of the police department! And, moreover,

no less than one third of the total were plucked, and cut off from practice.

Since such is the state of medical science, so called, in this part of China, what must the masses of the people suffer in times of illness, or accident, and at certain critical times? Were we not fearful of bearing too heavily upon the patience of our readers, we might give many instances of cruel suffering, of pain prolonged, and of life sacrificed, not only because of the absence of intelligent medical or surgical treatment, but undoubtedly because of hideous maltreatment at the hands of these very men who have so recently been licensed to practise. We abstain the more readily, because all who have lived in interior China for a few years are witnesses of these things.

Even though our friend, the candidate, from whose paper we have quoted above, has made a shrewd remark or two about the value of hygiene, there is no evidence that he has any practical knowledge of the subject. He is on much safer ground when he descants upon the importance of "a clear opening through the alimentary canal," and upon taking food and drink "in harmony with the needs of the system." As to the state of hygiene in West China, one has only to pay attention to the evidence of his own senses while walking through a few streets of city, town, or village; or, it may be, while visiting in the homes of some of the people.

Newcomen-Way.

We're about to have a Surgery remodelled and transplanted
(Sound the psaltery and sackbut to salute the gallant tale),
Where the dresser's lightest wish is instantaneously granted,
And the patients can be seen on an accelerated scale.

We're about to house the Externs in this mansion over yonder,
Where they won't share eight-foot bedrooms with the *pulex* and the midge,
And the gaiety or quarrel of the primitive Maze-Ponder
Won't disturb them as they're plundering the Charity at Bridge.

They will fill at morn and even their digestive apparatus
With a glad appreciation undismayed by thought of fee—
For enveloped in the halo of a residential status
They will board and lodge for nothing—in the spacious days to be!

We're about to have a hospital of unexampled glory
(Sound the timbrel, if you've got one, strike again the ancient drums),
But so long we've heard the story that by now it's old and hoary,
And we've gone to sleep with waiting. Will you wake us when it comes?

S.S.

Guy's Hospital Reports.

The Editors have for disposal a number of the older volumes of the Guy's Hospital Reports. These have been made up into sets, each of which, though not absolutely complete, contains between thirty and forty different volumes issued between 1836 and 1898. The earlier volumes are of particular interest, as they contain original papers by Bright upon albuminuria, by Addison, by Hodgkin, and by Sir Astley Cooper.

There are fewer copies to be had of some volumes than of others, so that the number of volumes in a set varies. Each applicant will, however, receive the most complete set available at the time his application is received. The volumes may be seen, by Dr. Pembrey's permission, in the Physiological Laboratory. The charge for a set to subscribers is 25s.; to non-subscribers, 40s., carriage paid.

Applications, which will be dealt with in the order in which they are received, must be accompanied by a remittance, and should be addressed to the Editors, Guy's Hospital Reports, 26, St. Thomas's Street, London Bridge, S.E.

Papers by Guy's Men.

Carcinoma of the Breast; its Early Recognition and Treatment. By R. H. Jocelyn Swan, M.S. Lond., F.R.C.S. Eng.—*Clinical Journal*, 4th March, 1908.

Presidential Address to the British Balneological and Climatological Society. By W. J. Tyson, M.D. Durh., F.R.C.P. Lond., F.R.C.S. Eng.—*Journal of the Balneological and Climatological Society*, January, 1908.

Future Lines of Treatment: Their Effects on the Profession. By W. J. Tyson, M.D. Durh., F.R.C.P. Lond., F.R.C.S. Eng.—*The Practitioner*, March, 1908.

A Clinical Lecture on Multiple Serosities, Illustrated by a Case in which the Abdomen was Tapped Seventy Times. By W. Hale White, M.D. Lond., F.R.C.P. Lond.—*British Medical Journal*, 29th Feb., 1908.

A Suggestion for Treatment in Delayed Chloroform Poisoning. By A. P. Beddard, M.A., M.D. Cantab., F.R.C.P. Lond.—*The Lancet*, 14th March, 1908.

Lymphangioplasty: A New Method for the Relief of the Brawny Arm of Breast Cancer and for Similar Conditions of Lymphatic Œdema. By W. Sampson Handley, M.S. Lond., F.R.C.S. Eng.—*Ibid.*

A Case of Hysterical Somnambulism, showing Abnormal Acuity of Vision in the Somnambulistic State. By James W. Russell, M.A., M.D. Cantab., F.R.C.P. Lond. *British Medical Journal*, 14th March, 1908.

Middle Meningeal Hæmorrhage: Trephining: Recovery. By Wilson Tyson, M.A., M.B., B.C. Cantab., M.R.C.S. Eng.—*Ibid.*

A Case of Phlegmonous Gastritis. By A. J. Hall, M.A., M.D. Cantab., F.R.C.P. Lond., and Graham Simpson, F.R.C.S. Eng. Illustrated.—*Ibid.*, 7th March, 1908.

Notes from Dr. Hertz's Demonstrations of Nervous Cases.

Case 1. Child two months old. *Paralysis of left arm dating from birth.*—In this case the labour had been a difficult one. The abnormality was noticed directly after birth, the arm not moving properly. On examination the left wrist was seen to be flexed, and the fingers flexed into the palm of the hand. The triceps was paralysed and quite flaccid, the biceps weak but not quite toneless. The deltoid appeared normal judged from a comparison of the two shoulders; the subscapularis was also paralysed. The triceps was very much wasted; a definite triceps jerk could be obtained on the right side, but none on the left.

Dr. Hertz said the case, which was one of birth paralysis, was a variety of Erb's paralysis. It was most often due to pulling on the arm; in this way the nerves of the brachial plexus were injured, being stretched or ruptured. The injury was usually inside the spinal canal. The fifth, sixth and seventh cervical nerve roots were usually affected, and appeared to be so in this case. Thus the fifth cervical supplies the deltoid, biceps, brachialis anticus and supinators. Sixth cervical supplies subscapularis and serratus magnus. Both these muscles help to fix the scapula. In this case the scapula was quite loose. This nerve also supplies the biceps. Seventh cervical supplies triceps and extensors of wrist and fingers.

Prognosis.—A good many children get perfectly well, as the nerves are not always completely ruptured.

Treatment.—The treatment was to keep the muscles in good condition by means of massage and electricity; then if the nerves regenerated, the muscles would be capable of carrying on their work. The best form of electricity was galvanism with frequent interruptions of current. The muscles react to galvanism and not to faradism. If at the end of two years the muscles were no stronger, it meant that the nerves had not regenerated. It then became a question of surgical treatment. Nerve-grafting was not much good. Fixation of the scapula, and shortening of the extensor tendons of the wrist would be the best treatment.

Case 2. Boy, æt. 6. *Right arm wasted.*—This case was also one of Erb's paralysis, being due here to an accident. When fourteen months old he fell on the palm of his hand with his arm extended. On examining this patient, the deltoid, spinati, biceps and supinators were found to be wasted, and the triceps to a less amount. The extension of hand and fingers was good. Patient was unable to put his hand straight out in front of him without the shoulder being elevated at the same time and the scapula moving forward.

In this case, the nerves affected were, part of the fourth cervical and the fifth and sixth cervical. There would be no chance of the nerves regenerating now, and the only treatment possible was surgical, *e.g.*, fixation of the scapula, or arthrodisis of the shoulder-joint.

Case 3. Girl, æt. 10. *Spasmodic closing of eyes, together with grimaces.*—Dr. Hertz, in discussing the case, said the general appearance suggested chorea. It seemed particularly probable, because she had had some pain in her hip which might have been rheumatic in origin. But there was something in connection with these abnormal movements of her face which did not correspond with chorea. Her arms and legs were quite unaffected, while in chorea these were affected as well as the face. Then, again, this patient could move or do voluntary movements perfectly well.

The next point was whether it might be due to peripheral irritation. There might be some irritation of the facial nerve or of the eye. It is not possible for a normal individual to close his eyes and at the same moment wrinkle up his forehead, though this can be produced by stimulation of the facial nerve. At her worst this patient shut her eyes, screwed up her mouth, but did not wrinkle her forehead. Irritation of the facial nerve or central irritation could therefore probably be excluded. In her case it was a movement which could be imitated exactly: a voluntary movement done involuntarily. It was a form of tic.

The way it started, as a rule, was by some source of irritation. In her case it might have been set up by an error of refraction which she had. In reading she may have screwed up her eyes. This, then, developed into a habit, and later on was no longer a habit, but tic, and came on involuntarily.

It was functional. Chorea was an organic disease. The treatment was correction of the defect by psychical means and exercises. The exercises consisted in voluntary movements of the affected muscles, *e.g.*, getting the patient in this case to open and close her eyes slowly several times, or to open and shut her mouth slowly. These and similar exercises to be done three times a day. While these movements were being done the spasmodic movements

could not take place. Dr. Hertz said some improvement was already noticed, although patient had only started the exercises the day before.

The severer forms of tic were practically incurable, though it was well worth trying re-education of the muscles by exercises.

Case 4. Female, æt. 24. *Hysterical monoplegia.*—This patient gave a history of having poisoned her hand last Christmas. This was followed by cellulitis of hand and arm, which got quite well. Then the present condition of stiffness and coldness of forearm and hand followed. Patient sometimes had slight pain in hand. On examination the fingers were extended and stiff. The hand and forearm were bluish in colour. She had been sent to the Electrical Department to have her muscles tested. They were found to react normally. Dr. Hertz said the lesion corresponded to no known form of peripheral neuritis. Then there was the history of poisoning and cellulitis, which cleared up, leaving the hand quite normal again. Later, only the hand assumed its present condition. If it had been directly due to the poisoning, one would have expected the neuritis to follow on at once. Then, again, although she had kept her hand in a rigid condition, she could move her fingers if she made an effort to do so. There was no wasting, and sensations of touch, temperature, and pain were normal. But hemianæsthesia of left side of body *in front*, and right side *behind*, was easily produced by suggestion. This definitely proved the whole thing to be functional. Similar conditions very often followed operations or injuries. The application of electricity to the hand was made, together with the suggestion that she would then be able to use it. She did so, though with a certain amount of stiffness resulting from the length of time the hand had been kept in one position.

Case 5. Male, æt. 54. *Early Case of Tabes Dorsalis.*—This patient came up to Surgical Out-patients, complaining of trouble in micturition. His urine escaped from him when he was walking about, and also during the night. The passage of a catheter showed the bladder to be nearly full, although patient said he had emptied it. No enlargement of the prostate could be found on rectal examination. He was then sent to the Medical side.

Examining this patient, his gait was found to be slightly abnormal. He showed a tendency to come down on his heels, rather than on the flat of his feet. The tendo Achillis and knee jerks were absent. His pupils reacted to light; the right pupil was smaller than left. Slight swaying was noticed when he stood with eyes shut and heels together. Also he showed some loss of muscle-sense and movement.

Taking into consideration the bladder trouble, the slight incoordination of movement, the marked Romberg's sign, the loss of reflexes, and also his statement that he could not do delicate movements with his hands as well as he used to, there was no doubt it was a case of early tabes. It was, said Dr. Hertz, a very good case for treatment. People might ask, "Why give this man exercises now—what was the good of it?" There was a great deal of good in teaching them exercises from the very beginning, so as to educate their other senses to take the place of their impaired muscle sense. By teaching them exercises these patients could be kept on their feet for years, instead of becoming bed-ridden. Urotropine was being given to this patient as a routine treatment, in order to prevent bladder infection.

Case 6. *Hysterical Monoplegia.*—This case was somewhat remarkable. It was that of a strong, healthy man of 30, with functional weakness of left hand. He had had influenza some time previously, and also pain in his left shoulder. Since his illness he had complained of increasing weakness of left hand. He could not grip so well, and now was unable to go on with his occupation, which was that of a carter. On examination, his shoulder was quite normal, and no wasting of muscles in hand or arm could be found. Electrical reactions of muscles were normal. He was treated by the suggestive influence of electricity, marked improvement being noticed.

Case 7. *Hysterical Aphonia in a man.*—Two years ago this patient lost his voice, and he has only been able to speak in a whisper since then. He knew of no reason to cause this condition. He was examined at Throat Out-patients and found to have bilateral adductor paralysis of his vocal cords. There was no organic disease known which produced such a condition, and the case was therefore functional in origin. An interesting point was that he could cough, but yet could not talk. Dr. Hertz explained that very little was of any good except electricity for these cases. At the same time, tell them you were going to make them well. They must be made to believe that something was going to cure them, and it would.

In this case electrical stimulation of the vocal cords instantaneously produced marked improvement

Case 8. *Cerebral Gumma.*—This was a case where a man had a severe headache since last September. So severe was it that he was unable to sleep, and his life was an absolute misery to him. He had also tenderness over the right frontal bone; there were no fits, neither was there any sickness. The eyes were examined and optic neuritis was found. All that he had then was optic neuritis and severe headache. Cerebral tumour was diagnosed. There were no localising symptoms. The question of removing anything could not be considered, for it was not known where the lesion was, though the tenderness suggested a meningeal origin. Then the question as to what sort of tumour it was. He gave a definite history of gonorrhœa, and a possible history of syphilis. Two small lumps fixed to the frontal bone had recently appeared. These were suggestive of gummata, so a diagnosis of a meningeal gumma was made. He was treated with mercury and potassium iodide (grs. xxv., t.d.s.). At the present time, three weeks after commencing treatment, he is free from headache, and the lumps are getting smaller.

F. J. W.

Appointments.

House Appointments.

The following appointments have been made by the House Committee upon the recommendation of the Medical Committee:—

House Surgeons.—Messrs. N. Flower, G. F. Stebbing.

House Physicians.—Messrs. M. M. Earle, J. N. Watson.

Assistant House Surgeons.—Messrs. W. W. Cook, H. J. Henderson, A. T. Densham, R. G. Chase.

Out-patient Officers.—Messrs. G. W. Dryland, E. B. Hind, E. P. H. Joynt, B. H. Palmer.

Obstetric Resident.—Mr. W. H. Trethowan.

Civil.

Maggs, Mr. W. A., has been re-elected a member of the Board of Examiners in Dental Surgery, at the Royal College of Surgeons of England.

Savatard, Louis, L.S.A. Lond., has been appointed Honorary Assistant Physician to the Manchester and Salford Hospital for Skin Diseases.

Turner, T., M.B., B.S. Lond., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed House Physician to the Sunderland Infirmary.

Webber, H. W., M.D., M.S. Lond., F.R.C.S. Edin., has been appointed on the Staff of the Devon and Cornwall Sanatorium for Consumption, Didworthy.

Notes of a Roving Guy's Man.

I.

As a centre for medical and surgical study, Berlin compares very favourably with other Continental centres, and a few notes on one's experiences here may not be without interest to Gazette readers. For English-speaking students there are many opportunities here, and for those who are acquainted with German there are many more. As everywhere else on the Continent, the new-comer is treated with invariable courtesy, whether student or qualified. He is freely allowed entry into the various public clinics, and, on presentation of his card, can usually obtain admission into many private ones as well. Living expenses, though somewhat higher than in other Continental University towns, are yet absurdly low. One can rent a room, without board, for 22 marks a month, and full board and lodging can be obtained for 70 marks. In the better-known—not necessarily better class—pensions, expenses are 20 per cent. higher, but for the moderate sum of £5 to £6 monthly the student can usually obtain excellent and comfortable board and quarters. If he wishes to make the fullest possible use of his time and opportunities, it is advisable that he should join the University and become a regular student. This is by no means "the fearsome process it sounds like." All that is necessary is to present one's card and credentials, a certificate of matriculation at one's own University (or its equivalent, such as the preliminary examinations demanded for the Conjoint Board), and to pay a fee of 12 marks. If everything is in order, the applicant obtains a card of honorary membership, as Gastzuhorher, which admits him to all clinical lectures, demonstrations, etc., for a period of one semester, or term. Presentation of this card at the Royal Library obtains a card of admission to the excellent reading-room—a much more common-sense method than the roundabout "householder" application that obtains at the British Museum reading-room. Fees for special courses are usually quite moderate. Thus, for a course of operative surgery, lasting a month, the fee is 40 marks, or £2. For this comparatively small sum the student has the privilege of working in a class which is limited to five members. There are daily (except on Sunday) meetings of the class, from 7.30 till 10.30 a.m., in the large operative-surgery class-room, close to the post-mortem room at the Charité. The operations, which are done under the supervision of Professor Hildebrand's chief assistant, Professor Pels-Lensden, include the whole gamut of things in the text-book, but, as most of the men are proficient enough in the ordinary operative methods of ligations, amputations, and excisions, special attention is paid to intestinal work. The subjects are either fresh, or, more usually, formalin bodies, and dogs. The latter are chloroformed, and all the work is done with the same scrupulous care and aseptic precautions which are observed in operations on the living subject. Among operations done this week in the class, I may mention cholecystectomy, posterior

gastro-enterostomy, œsophagotomy, annular gastrectomy, pylorectomy with anterior gastro-jejunostomy, ureterotomy and subsequent ureterorrhaphy, ileo-sigmoidostomy and gastrostomy in three different ways. A further course is to follow (fee 60 marks, membership limited to five) in lumbar anæsthesia, with operations on selected patients, at the Royal Surgical Clinic. These courses, of course, are not for students, but for qualified men who can show that they are either working for higher examinations, or for some special object. Most of the men are military surgeons, who have been "commanded" to one or other hospital for special courses in surgery, and who take these courses together with, if possible, a clinical assistantship. Such assistantships are sometimes available for foreign graduates. Thus, one of Professor Bumm's assistants is an old Bart.'s and Rotunda man, who tells me that he is learning more here than he could possibly learn at his old hospital—getting more opportunities for forceps work, versions and operative work, than fall to the lot of even a Rotunda "master." I hope to visit the Frauen Klinik under his guidance next week, although I am not specially interested in gynæcological work, for the picture he has drawn of the place is so attractive that it is well worth a visit.

There are several excellent societies here, and the visitor is made heartily welcome when he attends a meeting. An application to the secretary, Geheimrat Professor Ewald, of the Berliner Medizinische Gesellschaft, secures one a guest card which admits to the meetings of this, the first Berlin clinical society, on Wednesday nights, and to the reading room, which is one of the best I have seen—well arranged and well stocked. The Anglo-American Medical Association is another excellent, though of course a much smaller and less important society, but it is one which every English medical visitor should join. The president, Dr. Horner, who is the doyen of the foreign medicos practising in Berlin, makes the new-comer feel at home at once, and the members are all excellent fellows, keen on their "specialities," and eager and willing to place their experience at the disposal of the stranger in their midst. The society meets every Saturday night in room 5 at the Heidelberg Cafe, and my introduction was as informal and as reassuring as such a function well could be. I found the president busy with his supper, introduced myself, and ordered a Pilsener, while the president chatted in a discursive and interesting fashion, throwing out hints as to places of interest to see. By and bye the members strolled in one by one, and I was introduced. Each one ordered supper or beer, and soon the meeting reminded one of the smoking-room at lunch time. The signing of the members' book and the payment of a small fee (five marks) made me a member, and the cheerfulness and good humour of the assembly, which numbered several German visitors, made me feel quite at home. At half-past eight the president, supper being disposed of, called the meeting to order and the business of the evening commenced. Professor Cohnheim, who was to have lectured on hyperchlorhydria, being unfortunately unable to attend, a representative of the Leitz firm gave a demonstration of the new arc lamp light for microscopical work, together with a demonstration of living spirochætae and blood films. The physics of the new apparatus I am afraid I am unable to describe. The cells and organisms appeared brilliantly illuminated against a dark background, no shadows being cast, and the objects under the microscope appearing to stand out of the field with almost startling vividness. The apparatus can be fixed to any microscope possessing an Abbé condenser, and it was interesting to hear that, although the present model is a patent of Reichert's, the original model was made by an English microscopist, Stephenson, as far back as 1879. After this demonstration, the secretary announced the various courses which are open to members. A course in practical cystoscopy (fee 100 marks), one in practical laryngology with operative work (80 marks), one in diseases of the stomach (60 marks), one in psychiatry (50 marks), and so on. The association secures weekly a lecture by a well-known medical man. Next week Professor Oppenheim will lecture before it, and on the programme for the next few weeks are the names of Professors Alba, Cohnheim and Franck. In the Friedrichstrasse the association has a small reading-room which contains the latest German text-books and monographs, besides an assortment of German and foreign medical papers, including the *Annals of Surgery*, the *New York Medical Record*, and, indeed, most of the prominent American professional papers.

The hospitals at Berlin are, on the whole, finer and in better order than in most other German towns. The new Virchow hospital, which is probably the largest in the world, is specially interesting, not only because it shows the most modern improvements in hospital construction, but because it possesses the largest surgical department of any hospital in the city. The general hospital at Friedrickshain is probably the second largest, and after that comes the Charité. To the Charité is attached the Royal Chirurgical Polyclinic and the Royal Surgical Clinic at which the late Professor von Bergmann used to lecture. The Charité is in reality a small village, reminding one, in fact, of the large Ospedale Maggiore at Milan, and it is absolutely impossible to navigate its numerous departments in a day. One wants at least a week to get acquainted with its geography, and so far I have limited myself, in the afternoons at my disposal, purely to the surgical out-patient department. There is a large and well-equipped pathological department, attached to which is, as I was informed, a large pathological museum. On visiting the museum, which is really closed during vacation time, I found it to be quite a small establishment. The exhibits are in jars, which again are enclosed in glass cases, which are kept locked. It is, therefore, impossible to examine the specimens carefully. The collection is not large, and by no means representative. Being specially interested in œsophageal and intestinal growths, I naturally turned to these, and found to my disappointment that there were very few specimens of either class, and these old and badly preserved. There is, for instance, a specimen of the

lower bowel showing small dark nodules, labelled, probably correctly enough, "Melano-sarcoma intestinorum et peritonei," but nothing is said as to whether the growths are metastatic, as they most probably are. No reference number is given, and no details are available. There is no catalogue, and in the case of the two specimens I found interesting enough to make a note of —a carcinoma (?) of the lower bowel with dilatation instead of stenosis of the lumen of the tube, and a "syphiloma of the ileum"—it was impossible to obtain particulars. The collection is well arranged, and has its good points. Thus, the exhibit of parasites is very good, and so, too, is the collection of osteological specimens. The latter is particularly rich in specimens of osteomalacic deformity. There is a deformed skeleton of an osteomalacic woman of 28, the whole weighing just over three pounds. Another good feature is the collection of comparative pathological specimens and of wax models showing the methods of performing an autopsy. In the larger room there are some very fine surgical specimens; fractures of the base, recent hæmorrhages, cerebral and cerebellar abscesses being well represented. These specimens are new, and preserved so as to retain their colour. On the whole, however, the collection is far inferior to our own in the Gordon Museum, and any comparison with the Hunterian, or even the Dupuytren collection is out of the question. There are, of course, smaller collections and museums attached to the other hospitals. The anatomical museum is housed in a separate building—in the Royal Veterinary College, which is a handsome structure opposite the Charité.

At the Surgical Polyclinic (out-patients) at the Königliche Charité, Professor Pels-Lensden is in charge—a dapper little man with a spice of dry humour, who has the reputation of being one of the best clinicians in Berlin. His course for "practising physicians" is very largely attended, and I availed myself of his courteous permission to attend it whenever I pleased. As an illustration of the kind of clinical teaching which is given at these courses, I cannot do better than transcribe some of my notes, taken at last Saturday's demonstration. The demonstrations are given thrice weekly, on Tuesdays, Thursdays, and Saturdays, from two till four in the afternoon. Usually about ten cases are demonstrated, the majority being patients who have attended the Polyclinic during the forenoon. Sometimes, however, the Professor desires, or is asked, to demonstrate a particular lesion. Thus the men in the present course wish very much to see a case of acute appendicitis, and the professor has promised to demonstrate on one. The class is limited to about nine men, but the assistants and the "dressers" also attend. The patient is brought in, examined first by the Professor, who then invites the men to examine it, asks a few questions, and then discusses the case. The discussion is usually dogmatic. This, that, and the other are ruled out of court. *Davon Kann absolut nich die Rede sein* being the verdict until, by a process of elimination, the diagnosis, where possible, is established. Then the lesion is discussed, as such, its etiology, pathology, symptomatology, and treatment being briefly considered. Where operation is indicated, a scheme of the proposed method is outlined on the blackboard, and, in the case of minor operations, one of the class is asked to do it under novocaine anæsthesia in an adjoining room. Major operations are, of course, reserved, and the patients treated as in-patients.

On Saturday last the following interesting cases were shown:—

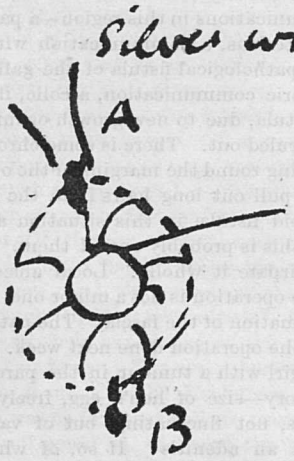
1. Keloid of neck in a young man. What else might it be? Microscopical pathology. Etiology—nothing known for certain. It is a common affection in Germany, especially among students, whose duelling scars are often keloidal. The microbic theory of origin was briefly discussed. The Professor is against operation, in general, as keloid usually recurs. Witness an interesting exhibit in the pathological museum (No. 62). On looking up this specimen, I find it is a model of Addison's keloid (thoracic keloid) before and after operation. The "after operation" shows, as is usual in such cases, a very much more extensive keloidal scar. In this case, incision under cocaine. "Who volunteers? You, Herr Collega? Ach, so! Very well. Next."

2. Umbilical fistula in a man of twenty-five. Three years' history. No urine has been found to escape from it, and it is evidently not a urachal fistula. Other fistulous communications in this region—a patent ductus omphalo-mesentericus, a communication with the pancreatic duct, a pathological fistula of the gall bladder, a tubercular enteric communication, a colic, iliac, jejunal or duodenal fistula, due to new growth or inflammatory processes—are ruled out. There is some chronic inflammatory thickening round the margins of the opening, and it is possible to pull out long hairs from the floor of the fistula. Dermoid fistulæ in this situation are not uncommon, and this is probably one of them. The treatment is to extirpate it wholly. Local anæsthesia will suffice; but the operation is not a minor one, as it means careful approximation of the fascia. The patient will be admitted, and the operation done next week.

3. A young girl with a tumour in the parotid region. Six years' history—size of hen's egg, freely moveable, elastic, painless, not fluctuating, but of variable consistency. Is it an adenitis? If so, of what nature? Tubercular and septic adenitis—their differentiation. Tubercle very rarely attacks the salivary gland, but the herrn collegas must bear in mind that there is a definite lymphatic gland lying on the parotid gland itself, and that this is not infrequently the seat of an adenitis. There are no other glands to be felt enlarged, and an adenitis *per se* is not diagnosable here. The tumour is a definite one, and its long history, relatively slow growth, painlessness, etc., point to its being a new growth, and not of inflammatory origin. Pathology of new growths of parotid. Epithelial remnants in the gland tissue, carcinomata, false enchondromata, sarcomata and mixed tumours, and encapsuled endotheliomata. Metastatic tumours in the parotid

region. Concretions, sialolithiasis. This case is probably one of encapsuled "mixed tumour." These mixed tumours are really endotheliomata; clinically benign they are, from a pathological point of view, to be classed among the malignant tumours. They are of slow growth, but may suddenly grow rapidly. In this case removal would be easy, and would not interfere with the facial nerve. Possibility of preserving facial nerve in operations for malignant disease of parotid discussed; exceedingly difficult, if not impossible; better, perhaps, to remove the nerve, and clear away as large an area as possible.

4. Prolapse of rectum in a child of six months. Notice the laxness of the sphincter, which has, however, still a moderate constricting function. Etiology of prolapse in children, usually bad feeding, leading to diarrhœa and wasting. The wasting diminishes the fat in the cellular tissue behind the rectum, and this laxity of the subrectal tissue is probably the active cause of prolapse. In adults, causes more serious and usually higher. Function of mesentery of upper part. Large prolapses pulling down the peritoneum; herniæ due to prolapse. Treatment: dietetic in all cases. Usually proper feeding and the wearing of a pad correct the prolapse in the course of a few weeks. If not, operation is required. In the case shown this is simple and is done at Out-patients. A small incision is made just in front of the



anus at A, and a silver wire is inserted subcutaneously, and brought round to a point B, opposite the original incision. Here it is again inserted subcutaneously, and carried half round anus to emerge at the original incision at A. The wire is placed fairly deep, the finger being in the rectum of the child to guide the wire, and prevent the bowel from being pierced while the wire is inserted. When pulled out at A, a loop of wire lies loosely in the subcutaneous tissue round the anus. The ends of the wire at A are then twisted with a special instrument (an ordinary strong pair of wire forceps will serve) till the ring is just tight enough to allow the finger to be easily withdrawn from the rectum. The ends of the wire are then cut off flush, and the edges of the incision at A sewn over them. The wire is taken out after a week, or is left in for a much longer period if the operation has been done aseptically. In many cases it is left in for months. It acts as a mechanical block to the prolapse, and allows the sphincter time to regain its function. The operation is simple, and, provided proper dietetic treatment is insisted upon, is very successful. Operations in more severe cases. Fixation methods: why they fail. Complications of prolapse; hæmorrhoids.

5. Carcinoma of right breast—demonstration of examining breast tumours—value of history of patient in such cases—course and progress of disease. Questions of operation. This demonstration elicited nothing very novel. Total removal of the pectoral was advised, and, as is the teaching at Guy's, it was stated that free movement of the arm would result, provided the limb was not bandaged in a cramped position. The pathology of breast carcinomata was touched upon, but only cursorily, and by no means so ably, as in the case of the parotid tumour.

6. Fracture of radius (Colles).—A correct description was given and very full details about diagnosis, though the case was by no means a typical one, being an old impaired fracture. Advisability of disimpaction: disimpaction best done by strong dorsal flexion. No splint necessary: the arm is simply bandaged, the hand being put in a position of radial abduction. A sling is worn with the hand carried well forward and unsupported. The treatment, in fact, is that recommended by all the latest authorities, and differs from that carried out in France and at the Italian hospitals where, in many cases, modifications of the old Nelaton's splint are still in use.

7. Bennett's fracture, reduced and treated by means of a thin wooden splint. The fracture was not explained, and it was evidently well known to most present. With us it is distinctly a rare lesion, and few Guy's men would be able to explain what it is. So far as I recollect, Thomson and Miles' text-book gives an excellent description with photograph of this fracture, of which I have only once before seen an example at Out-patients at the Exeter Hospital. Bennett described the lesion in 1896, and here his name is attached to it, although neither Colles nor the French surgeon, who, many years before Colles, wrote an exact account of the fracture of the lower end of the radius, is credited with the discovery of the latter fracture.

8. Synovitis and disorganisation of left knee-joint in a woman of 32. Both pupils reacted to all stimuli, but the knee jerks were absent, and abdominal reflexes sluggish. A good example of a flail joint, probably neuropathic in origin. This case was only shown to discuss the diagnosis. Treatment was not considered.

9. Recurrent hip abscess in a girl of 24, operated upon ten years ago for hip disease. Movement fair and painless, and patient has been well since operation up to a fortnight ago. At present a large abscess over trochanteric region. The question of a recrudescence was discussed. Treatment: evacuation of abscess and thorough

exploration to find the probable sequestrum. No drainage, and operation to be performed with rigid asepsis. The case showed the uncertainty of "cure" in such cases, even after a prolonged period of rest.

10. Phlegmon of hand and forearm.—"This patient, herrn collegas," says the Professor, "had a small abscess in the palm of his hand, and, of course, knew better how to treat it than all the doctors in Berlin. So he—What did you put on it? Bread and butter? Ah, well, you see for yourself the result." The whole forearm was enormously swollen and œdematous. There was an open wound in the palm, discharging thin fœtid pus, and a smaller wound just above the wrist. The œdema extended up to three inches above the elbow. Treatment by Biers' method, which was applied at once. A thin elastic web bandage was put on over the upper arm just above the deltoid insertion. It was put on just tightly enough to control the venous flow, the pulse remaining palpable at the elbow, though, owing to the œdema, it was impossible to feel it at the wrist. The technique of Biers' method explained and discussed. The bandage must be applied till the arm becomes red and blotchy, but must be loosened when pronounced lividity ensues. The immediate result is that the arm becomes engorged with blood, which drips from the two wounds; the patient complains of pain, which, however, soon passes off. Patient is to be watched, and the bandage loosened or tightened as may be necessary. The bandage is kept on for a period of from ten to twenty-four hours, the two wounds being incised, though not so deeply as to lay open the sheaths of the tendons. A few strips of gauze are inserted, but on no account are the wounds to be packed. The essentials of the treatment are to cause a local hyperæmia, "a passage of humours from within outwards," and in cases where the bandage is inapplicable, cupping-glasses and superficial scarification are used. Much attention has recently been paid to this method, and a series of excellent articles on the subject has been in Langenbeck's Archiv, but the method is still on its trial, and Professor Pels-Lensden criticised it fairly severely. He stated that he had not had much experience of it at the Polyclinic, where patients could not receive the requisite attention and personal care which the method called for. In in-patient practice the results were on the whole indifferent. The method was open to grave risks. Patients never complained of great pain, it is true; in fact, the treatment was to a great extent an analgesic, but the application of the bandage was usually followed by a pronounced *rise* of temperature, by restlessness, and sometimes even by severe rigors. Formerly, when he was assistant surgeon, such phlegmonous conditions were treated by free incisions and vigorous packings, with the result that very often most unfortunate contraction resulted owing to the sloughing of tendons. Under Biers' treatment he had seen equally bad results due to the same cause. Nor was it settled as to what conditions were quite suitable for such treatment. Streptococcal cases did badly, whereas staphylococcal and mixed infection cases did better. Acute conditions on the whole responded better to the treatment than chronic. Perhaps the best treatment of phlegmonous conditions was by means of incisions deep enough to give adequate drainage, but not so heroic as in former days. Packing was to be condemned in every case.

11. A small boy with apparent shortening of the right leg, which was in a position of flexion and slight adduction. There was absolutely no impairment of mobility at the hip-joint, flexion, rotation, adduction and abduction being normal. There was no pain or tenderness, except on deep pressure in the right iliac fossa, when the child, who was an extraordinarily bright and cheerful laddie, stated that it hurt him in the neighbourhood of McBurney's point. No signs of spinal disease, and rectal examination quite negative. Hip disease was discussed and ruled out; so also herniæ in unusual situations, and the Professor inclined to a diagnosis of "primary psoitis." Inflammation of the psoas was most commonly due to an inflammatory inguinal adenitis, of which, in this case, there was no evidence. Appendicitis, tubercular peritonitis, and tubercular enteritis were discussed. When the psoas was put in action, the boy holding his leg up without support, it was possible to dip down into the right iliac fossa, and to palpate the psoas and appendix. In such cases, where there is a possibility of tubercular peritonitis, careful search should be made for any matting or lumps in this and other situations. A rectal examination should never be omitted, and, in children, a hernia should always be very carefully examined, as it is sometimes possible to feel a lumpy intestine through the relatively thin integuments covering a hernia in children. In the present case, the Professor was inclined to think that appendicitis, probably catarrhal, and involving an appendix that lay to a great extent extra-peritoneally, was the source of the flexion of the hip and involvement of the psoas. An attempt to elicit Rosving's sign, (pressing down with both hands from the transverse colon downwards towards the cæcum, so as gently to force the gases and bowel contents backwards, when the patient feels a sharp stinging pain, not in the region palpated, but at a point just over the tip of the appendix) was negative. An attempt to eliminate kidney trouble was not made.

12. Finally, the Professor gave a demonstration of the manufacture of a plaster cast for a knee case, such as No. 8. The cast is made over a plaster model, more or less of the size and shape of the patient's knee, if an accurate cast cannot be made to serve as a mould. The plaster is covered with a layer of thick flannel—a large thigh stocking serves admirably—and the material is then spread over it evenly with a painter's brush. This material is celluloid solution. Celluloid shavings, which are to be had for a song from celluloid factories, are dissolved in acetone (the Professor remarked that, at a pinch, a diabetic patient might oblige, if the dispensary was out of acetone), forming an even, gruelly mixture, which is laid on in two or more coats and well worked in. The plaster may be made of any thickness, but the more

coats are spread the longer it will take to set. Finally, the plaster is cut open along the front, the edges sewn over with thin leather or felt, eye-holes punched for lacing, and the whole polished. The finished article is a superior kind of thing, before which our best Croft's must crumble up from shame. It is light, adaptable, strong, and yet flexible. Its great drawback, of course, is its inflammability. Here these plasters are dried in steam ovens, or, in summer, outside in the sun. They are much used, and are all made on the premises, either by the nurses or by one of the male attendants. It seems to me that, for all practical purposes, our Croft's are superior, inasmuch as they are simpler to make, requiring no preliminary mould, and that they take less time to set, but here, gypsum is gradually being displaced by celluloid. For spinal jackets, wristlets, and upper-arm supports, celluloid seems preferable to poroplastic, which is so expensive, and which, in dressers' hands, at least, so very rarely gives satisfactory results.

The work at this Polyclinic is very interesting. Two chief assistants are in charge, and there are five senior students who act as dressers. Patients receive a card bearing a number, which is entered in a special reference book, along with the diagnosis, treatment, and any special remarks. Special cases, such as are probably to be subjected to major operations, are reserved for the Professor's opinion. He comes round at two o'clock, sees the cases, and either treats them there and then or refers them to the in-patient department. The rooms are large and airy, with cement floors and walls, and, as in all the clinics here, with double windows. The heating is throughout by hot-water pipes, and each room contains an independent sterilising apparatus and a boiler for normal saline solution. The ventilation is very good, on the whole, the rooms being free from any musty smell so often met with in Out-patients, where the modified plenum system is used. I noticed in two rooms that there were heavy window curtains, and was told that these were "to be removed years ago, but no one has taken them away yet." Out-patients starts at half-past ten, and no patients are seen after two o'clock. The porter acts as selection committee, and turns away all obvious eye and ear cases to their respective clinics. The assistants in charge of the clinic are both military surgeons, who have been "commanded" for a special course in surgery, and who draw their pay as officers. They examine each case carefully, listening to hearts and lungs in many cases, and demonstrating to the dressers on some special case. The diagnosis was in most cases easy. Two cases presented some difficulty—a boy with a small, hard, non-fluctuant swelling on the ulnar aspect of the forearm, just above the wrist, and an old woman with very marked scolio-kyphosis dating back only three weeks. The general opinion was that the swelling was a ganglion, but I thought it was much more probably a tubercular swelling with secondary infection progressing to abscess formation. The old lady I could not diagnose. An osteomyelitis of tubercular or septic origin seemed out of the question, as there was no tenderness, and the lesion had all the appearances of being an old one. The patient nevertheless persisted that it was of quite sudden onset. The Professor examined her, but only cursorily, and sent her to the gynæcological department! The ulnar swelling he held to be streptococcal, pointing out that it lacked the "blueness" usually seen in tuberculous cases, and that there was slight œdema around it.

Minor operations are done by the assistants after two o'clock. Local anæsthesia (usually novo-cocaine and adrenalin) is used, except in the case of small children, who are given chloroform. This is administered by the drop method on a Schimmelbusch, the anæsthetist being the dresser or the attendant, who acts as Jack-of-all-trades. The instruments are in charge of the nurse, who is a very efficient individual at everyone's beck and call, retaining, amidst all her troubles, a serene placidity of countenance and a glibness of repartee which are as impressive as they are doubtless valuable. The clinic has a very large and well-stocked instrument case, and there is no stinting in bandages, splints, dressings, etc. Here, though not in the general clinic, iodoform wool is still used, with iodoform gauze. Strychnine is not to be found; camphor injections (5 per cent. in olive oil) and ether have quite displaced it. The minor operations offer little of interest. Phimoses are carefully done and as carefully sutured, a dressing of iodoform gauze being applied and the child taken away at once by its mother. A ranula is completely extirpated, the carotid being compressed by the assistant's finger and the tongue drawn forward by a ligature. Tongue forceps are not used. Varicose veins are bandaged with a gelatin bandage (Unna's paste), several layers being applied so that a really firm support is given.

C. L. L.

Berlin, March 20th.

Change of Address.

Dr. T. F. L. Blaker from 38, Harrington Road, Preston, Brighton, to 92, Beaconsfield Road, Preston Park, Brighton.

Captain F. M. M. Ommanney, R.A.M.C., from Upper Topa to Sialkot.

Dr. R. J. Roberts from 71, Whitehall Park, London, N., to "Upny," Ventnor, Isle of Wight.

Dr. T. Turner from the Chesterfield and North Derbyshire Hospital to the Sunderland Infirmary.

Captain M. C. Wetherell, M.D., from Campbellpore to Rawal Pindi, India.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the Gazette *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated.*

The Treatment and Filling of Root Canals.

DENTAL CLINICAL LECTURE,
By Mr. J. Lewin Payne.

Gentlemen,—In the treatment of root canals we have the most important field of our labours that is not open to visual inspection, and though the process is one which must always play a prominent part in the dental surgeon's daily routine, yet I venture to think that it has received, relatively to its importance, less attention than almost any other branch of our practice.

It is true that many root fillings are carried out with extreme care and exactness, and the majority serve their purpose fairly well; but there remains a proportion which must be accounted failures, and most of these can be attributed to empiricism in treatment.

How common it is to find strong antiseptic or astringent drugs used in cases where there is neither sepsis nor hæmorrhage. A bland essential oil would cleanse the canal quite effectually without the risk of injury to the soft tissues outside the root which the stronger drugs involve.

Then, in the case of septic roots, many are satisfied to wash out the canals with the first, or it may be the strongest, antiseptic which comes to hand, forgetting that there is something more than the germs causing the sepsis, which needs treatment. Products of decomposition in most cases are poisons, and keep the mischief active: these must therefore be destroyed.

The methods in vogue are many and diverse, but it is hoped that this lecture may help to clear the ground rather than add to the confusion which already exists. In the first place, wherever possible, the root canals of devitalized teeth should be completely filled. To allow dead organic matter to remain exposed to microbic infection, or to leave a cavity in which germs can multiply, is not only harmful, but it is also quite contrary to the surgical treatment of other parts of the body.

One might just as well leave masses of carious dentine at the bottom of a cavity as permit any pulp tissue to remain in the root canal of a devitalized tooth. But there are cases in which it is quite impossible to remove every trace of the pulp, and these require a special treatment, to which I shall refer later.

The ideal root-filling should comply with the following conditions:—

1. It should completely fill the canal, and adhere to its walls.
2. It should be impermeable to fluids.
3. It should perfectly seal the apex of the root.
4. It should have antiseptic properties.
5. It should neither expand nor contract after its insertion.
6. It should be easy to insert.
7. It should not act as an irritant to the surrounding tissues.
8. It should not discolour the tooth.
9. It should not be unpleasant in taste or smell.
10. It should be durable.
11. It should be capable of being easily removed in case of necessity.

There is no substance which fulfils all these requirements, but by using a combination of methods it is possible to attain practically all that is demanded.

The cases which have to be treated may be divided into three groups:—

(*a.*) Simple cases, in which the canals can not only be easily opened up, but where they can also be sterilised, without protracted treatment.

(*b.*) Tortuous roots, and those with canals so fine or flattened that no broach can be satisfactorily inserted.

(*c.*) Intractable septic roots.

It will not be necessary to lay stress on the importance of asepsis in all cases, nor upon the value of applying the rubber dam to the tooth wherever such treatment is possible.

If any difficulty arises in gaining free access to the canals, do not hesitate to cut freely into the crown, remembering that the conservation of the root is always of greater importance than that of the crown. What is the value of saving a small portion of the occlusal surface of a tooth if it is to be followed by an alveolar abscess? The failure to open up freely, is often the first blunder.

A knowledge of anatomy is also essential, and it is not sufficient to remember that there are normally three root canals in a molar; we must know exactly where to look for the lumina of these canals. The removal of pulp tissue is best accomplished by means of Donaldson cleansers or Beutelrock broaches and drills, but very fine or flat canals cannot be cleansed by mechanical means alone, and chemical agents are then employed, for if the mechanical treatment is pressed too far in such teeth, one runs the risk of either puncturing the wall of the root, or breaking the instrument in the canal.

Hydrogen peroxide has proved itself a most valuable drug in this branch of dental work. With its aid we are able to remove minute traces of pulp tissue, which in days gone by would have been left to decompose. The use of 20 per cent. H_2SO_4 has also been recommended.

Apart from the risk of sepsis, the pulp remnants are a frequent source of the discolouration so commonly observed in devitalized teeth.

With teeth coming under group (*a*), after the complete removal of soft tissues, the canals should be cleansed with a bland essential oil, such as cajuput, or some other simple and non-irritant drug. Then dry with absorbent wool and stiffened points. If this is followed by absolute alcohol, and heat applied with the electric root drier, the desiccation of the canal will be complete.

In cases where the canals are not only free from septic organisms, but where they can also be opened sufficiently to admit an ordinary broach, the roots are best filled with thin oxyphosphate cement, glutol, and non-absorbent

cotton-wool. The filling is prepared by mixing nine parts of oxyphosphate powder with one part of finely-powdered glutol, and the mixture is then made into a thin creamy paste by adding, and well incorporating with it, liquid phosphoric acid.

By means of a fine broach, some of this creamy mixture is coaxed into the pulp canal until the latter is apparently filled; then taking a tiny wisp of non-absorbent cotton-wool, with two fingers of the left hand twist it round a fine broach in such a manner that it may be easily slipped off when required. The non-absorbent wool is next impregnated with the creamy paste just mixed, and is gently pushed home into the canal. Usually the broach can be removed without difficulty, leaving the impregnated wool behind, but if the wool tends to be dragged away, insert another fine broach alongside, and thus hold the wool in position until the first broach has been removed. In order to completely fill large canals it is sometimes necessary to insert two, or even three, wisps of cotton-wool so treated.

Glutol, which is used in this root-filling chiefly for its antiseptic properties, is produced by the action of formaldehyde on gelatine in an aqueous solution.

It is an odourless, non-irritant, and non-staining antiseptic, which constantly liberates formaldehyde, and keeps the part dry. The advantages of such a root-filling are:—

1. It is comparatively easy to completely fill the canals by this method, and the filling adapts itself to the walls.
2. It is antiseptic and non-irritant.
3. It helps to preserve the colour of the teeth.
4. If a small quantity of creamy osteo should exude beyond the apex, it will do no harm.
5. It forms an osteo floor ready for the insertion of the permanent filling.

In dealing with cases coming under group (*b*), where the canals are either so tortuous or fine that it is quite impossible, by mechanical or chemical methods, to remove the whole of the pulp, a preparation of carica papaya and colza, known as "caroid solvent," may be employed. This is made from the ferments of carica papaya and colza, and its action on the pulp is that of a digestive agent. A few drops of the solution are applied to the canals on cotton-wool, and after twenty-four to forty-eight hours the dressing may be removed, and with a saturated solution of sodium bicarbonate its acidity should be neutralised. The pulp canals can then be filled so far as their shape and size will permit.

In the third group of cases, it is important to bear in mind the chemistry of pulp decomposition.

You will remember that the pulp consists of ordinary animal tissue, *i.e.*, it contains proteids, fats, carbohydrates, salts, and water. In the process of decomposition, putrescin, cadaverin, and neuridin are formed, and these are further broken up into ammonia (NH_3), hydrogen sulphide (H_2S), water, etc.

Now, as was stated at the outset, in the treatment of these cases, it is not enough to destroy the germs which cause the sepsis; we must also get rid of these products of decomposition, which are acting as virulent poisons to the soft tissues. For this purpose, formalin is a valuable drug, uniting, as it does, with ammonia, one of the end products, to form urotropin, a solid, and also with hydrogen sulphide and the basic ptomains. The official solution is, however, too strong for use, and we require, in addition, some solvent of the fatty products. Tricresol has, therefore, been recommended by Dr. Buckley as a fat solvent, and to act in combination with 1 per cent. formalin.

At the second visit peroxide of hydrogen and hot water should be applied, and in most instances the filling can be inserted forthwith, but if the root still remains septic, use a dressing of phenol-sulphonic acid.

The phenol-sulphonic acid is prepared by heating phenol in an evaporating dish, carefully adding sulphuric acid, and then water, whilst hot. The apex is sealed after the root has been thoroughly dressed twice, or at most three times, and then if further treatment should be necessary it must be carried on through the outer alveolar wall. Prolonged dressing of root canals is pernicious; as long as the apex is kept open, so long will the abscess remain active. When a fistula exists, the drugs employed should be forced through the apex to the sinus on the gum.

It is well to ream all cases coming under group (*c*), and the canal may be considerably enlarged so that the dentine which has been bathed in septic fluids may be removed, and the root more readily disinfected, but great care must be taken, especially on first opening the canal, to ensure that the septic matter is not forced through the apical foramen.

Other methods which have met with considerable success in cleansing septic root canals are the sodium potassium treatment, and the use of a constant galvanic current of 1 to 2 milliampères acting for 10 to 15 minutes.

After the preparatory treatment is complete, the root can be filled with osteo-glutol as before, but if fears arise as to the necessity of re-opening the canal, a post or gutta-percha point may be inserted in the central portion of the root-filling and extended down to the apex.

Appointments.

Naval and Military.

Fleet Surgeon Horace B. Marriott, R.N., has been appointed to the *Niobe*, and Fleet Surgeon Arthur E. Kelsey, M.B., R.N., to the *Lancaster*.

Surgeon A. W. Iredell, R.N., has been appointed to the Royal Naval Barracks, Portsmouth.

Royal Army Medical Corps (Volunteers).—George L. L. Lawson (late Surgeon-Captain, 6th Regiment, Imperial Bushmen, New South Wales), to be Lieutenant in the London Companies.

Reviews, etc.

The price of books submitted for review should in every case be stated.

Hernia: Its Etiology, Symptoms, and Treatment. By W. MacAdam Eccles, M.S., F.R.C.S. Lond. (Baillière, Tindall & Cox, 8, Henrietta Street, Covent Garden, W.C., 1908.) Third edition. Cloth, crown octavo. Price 7s. 6d. net.

This is emphatically a student's book, and as such it possesses all the merits, and a few of the defects, which belong to that class of manual. The defects are general defects; they belong to the class, not to this particular specimen of it so much as to others of the same type. A student's monograph must of necessity be elementary, and it is impossible in a work like this, wherein brevity and condensation must, above all things, have paramount claims to consideration, to go very fully into interesting but debateable questions such as the pathology of strangulation, or the theory of hernia generally.

Not that Mr. Eccles passes these interesting problems by in silence. He has something to say about them all, and he says it, necessarily, with a certain amount of dogmatism that must be inseparable from such student's books. We have no fault to find with what he includes. As a clinical teacher, he knows the full value of the relative importance of symptoms. We have, therefore, in this book some very clear and concise tabulations of the differential symptomatology of various conditions that may be mistaken for hernia. A little more stress might have been laid, with advantage, perhaps, upon the physical examination of a hernia. Nothing is said, for example, of the importance of differentiating scrotal from inguino-scrotal swellings—surely, we should have thought, the very first thing that the student should be taught—nor of the danger of incautiously "invaginating" the tissues into the external ring when examining a small or doubtful rupture.

The chapters on treatment are excellent, and students preparing for their final should read them carefully, as they are abounding in useful hints and satisfactory descriptions of trusses. In a future edition, Mr. Eccles should qualify the statement, which occurs on more than one page, that "the truss should be worn night and day." No truss, we should imagine, that is effective for day use will be of the slightest good when worn at night. This is a point on which few of our text-books and few of our teachers lay much stress, but we believe, nevertheless, that it is one of the most important points in the treatment of hernia by trusses. A brief consideration of the anatomy of inguinal hernia should be sufficient to show that for night wear a much lighter, and preferably a springless, truss is desirable, and that the strong day truss is absolutely unsuitable.

With these few criticisms—to which we might add the complaint that the book is printed on very highly-sized paper, making its reading by lamplight a weariness to the eyes—we will stop our carping. But Mr. Eccles' work is so well known and appreciated that a résumé of its good qualities is an entirely superfluous task. Suffice it to say that this, the third edition, is thoroughly up to date, revised and added to, and eminently suitable for students' use. The illustrations, which are a feature of the work, are mostly taken from actual photographs, and are, therefore, particularly valuable. The book is one which should be read by every surgical student before he "goes in" for his final.

Surgical Applied Anatomy. By Sir Frederick Treves. Revised by Arthur Keith, M.D., F.R.C.S. Fifth edition, 1907. (Cassell & Company, Ltd.)

This edition has been entirely revised by Dr. Keith, who has included a mass of valuable new information in the comparatively modest amount of space which the size of the book allows. Forty-three new illustrations, some of them in colours, have been added, and they all elucidate the text—some very much so, for here and there the descriptions given in the letterpress are still somewhat obscure. The little manual remains what it was when it was first issued—an invaluable addition to the student's library, and the thorough revision and enlargement which it has undergone has materially added to that value. It is a book that can be heartily commended to the attention of students.

Hygiene and Public Health. Parkes & Kenwood. 3rd edition. (H. K. Lewis.) Pp. 630. 10s. 6d. net.

The work has been carefully revised and brought thoroughly up to date by the conjoint authors. Some of the older matter has been omitted or compressed, and a fair amount of new material inserted, the size of the pages being enlarged to obviate unduly enlarging the book. The type is of a nice size and particularly easily read. The water section is particularly good and up to date, dealing with this important subject very fully. The various systems of sewage disposal are also described and contrasted in a very able manner, the latest experiments of various commissions and other observers being mentioned. We can thoroughly recommend this work to students of Public Health as giving all the most important points in connection with this important branch of medical study, fully, concisely and thoroughly up to date, without being dull or uninteresting—in fact, from a student's point of view, it is the best book we know.

Papers by Guy's Men.

A Clinical Lecture on a Case of Addison's Disease. By W. Hale White, M.D. Lond., F.R.C.P. Lond.—*The Clinical Journal*, 18th March, 1908.

Observations on Cheyne-Stokes Respiration. By M. S. Pembrey, M.A., M.D. Oxon.—*Journal of Pathology and Bacteriology*, January, 1908.

Sport.

Association Football.

GUY'S v. ST. THOMAS'S.

Final Junior Soccer Cup.

This, the last game of the season, which was played on Saturday, March 21st, was fought out against St. Thomas's Hospital 2nd XI. on their own ground at Chiswick, and resulted in our securing the Cup by the narrow margin of 1–0. There were two changes in the team which had led us up to the Final. Lewis Jones, our inside-left, was an absentee, and Gibbons, our centre-half, had been required by the 1st XI. for their last two Cup-ties.

Ground and weather conditions were ideal, but compared with our other games, this match did not come up to the standard. It may have been the fact that St. Thomas's supporters numbered some eighty to our two or three. Time came with no score on either side, and it was while we were playing an extra quarter of an hour each way that we scored. The goal was not a neat effort, but was rushed through from a corner kick, which Cook placed well in the goal mouth—a repetition of what he did in our last Cup-tie.

The forwards who showed up most through the game were the two outside men, Mitchell and Cook. The three inside-forwards, Wain, Edey and Eccles, did a lot of work, but their final efforts seemed to finish up unfortunately.

Of the halves, Townrow (although he has played but little this season) served us well. Edmond and Keer played up to their usual game. Both Hole and Johnson, at back, played sound Cup-tie games.

To Rook, the goal-keeper, much praise is due. He saved what looked like two certain goals—two hot shots from under the bar. The Cup, which has rested at the London Hospital for one season, will now return to the Smoking-room. Team:—

Guy's.—H. C. Rook (goal); K. H. Hole and W. Johnson (backs); J. A. Edmond, V. Townrow and K. J. T. Keer (halves); W. W. Cook, D. Wain, H. N. Eccles, F. H. Edey, and D. A. Mitchell (forwards).

United Hospitals Cross Country Club.

The annual race for the Kent-Hughes Challenge Cup took place on Saturday, March 21st, at Blackheath, from the Headquarters of the Blackheath Harriers. London Hospital, the holders, were unsuccessfully challenged by Guy's, the holders winning by the small margin of 25 points to 32. The trail was laid over a long 9½ mile course, by Tom Crafton and two other Blackheath Harrier Officials.

Timekeeper: Mr. Fowler-Dixon, L.A.C. Judges: J. Brotchie, London Hospital, W. H. Watson, Guy's Hospital.

The competitors finished in the following order:—

				Min.	Sec.
1	Parsons ...	London ..		57	27
2	Armitage ...	London ...		57	43
3	King, L. A. B.	Guy's ...		57	57
4	Carr ...	London ...		58	33
5	Palmer ...	Guy's ...		61	17
6	Field ...	London ...		61	55
7	Levinson ...	Guy's ...		62	36
8	Stewart ...	Guy's ...	}	62	55
9	Cook, F. ...	Guy's ...	}		
10	Johnson, W.	Guy's ...		62	56
11	Eccles, G. D.	Guy's ...		67	50
12	Chapman ...	London ...		67	51
13	Palmer, A. ...	London ...	}	79	55
14	Mahaffy ...	London ...	}		
15	Moberly ...	Guy's ...			
16	Hodges ...	London ...			
17	Todesco ...	London ...			

King, of Guy's, although suffering from a sprained leg, ran a game race, and was leading the field on entering the road mile home, where he was compelled to pull up owing to sickness. Palmer, Levinson, Stewart and Cook are to be congratulated on their form, resulting from the training they underwent in previous weeks.

This race concludes the season, which has not been marked by great success in procuring a quantity of runners; nevertheless we have taken first places by the excellent running of Parsons and King, backed up by a long tail.

Golf.

A Meeting was held on March 26th, Dr. Cameron in the chair. It was decided to form a Guy's Hospital Golfing Society. It was unanimously resolved that Dr. G. Newton Pitt should be asked to act as President. The following were unanimously elected Vice-Presidents:—Dr. J. W. Fawcett, Mr. F. J. Steward, Mr. C. H. Fagge, Mr. A. W. Ormond, Mr. H. L. Eason, Dr. H. C. Cameron, the Rev. A. Lethbridge. The following were elected on the Committee:—Messrs. M. M. Earle, H. V. Gibbons, F. Morres, F. D. Saner, W. S. Kidd (with power to add two to their number from the men in the Dissecting Room). Mr. L. Bromley was elected Secretary.

It was agreed that a letter should be written asking the Clubs' Union for affiliation, and a grant of money. It was proposed and carried, that the head-quarters of the Society be at Chingford. With a grant from the Clubs' Union, the Golfing Society would be in a position to hire a Club Room close to the Links, and refund to members some portion of the green fee paid to the Chingford Club. (The existing fee is one shilling for each round of 18 holes.)

Marriages.

BEADNELL—SHELDON.—On 28th March, 1908, at St. Andrew's Church, Worthing, by the Rev. Layard, Captain Herbert Owen Marsh Beadnell, R.A.M.C., youngest son of Major C. E. Beadnell, R.A., J.P., of Hafod, Llandinam, to Mabel, only daughter of John Sheldon, Esq., of Tilehurst, Reading.

HODGSON—SAPSFORD.—On January 20th, at St. Stephen's, Newtown, Cortis R. Hodgson, M.D., B.S. Lond., Dulwich Hill, Sydney, N.S.W., to Janie E., daughter of the late T. H. Sapsford and Mrs. E. Sapsford, Hatton, Marrickville.

Ed.—L. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

OF late many of our readers must have noticed the increased space devoted in the lay journals to subjects which, if not entirely medical, are at least of a pseudo-medical interest. If it be not some biassed utterance of a medico-jurist on the much-vexed anæsthetic administration question, it is a highly-coloured inexact account of some marvellous "new" operation—the original probably having been performed centuries ago—or some miraculous cure. It is good to see this increased interest, but why will not these journals treat medical generalities in the same sane strain that they do other subjects? Much good could be done, we feel sure, if certain of our great dailies would but discuss questions of hygiene from a more rational point of view; for example, some benefits will accrue from the recent "pure milk" campaign which has of late been instituted. In the French lay journals such an all-important question as the general prophylaxis of tuberculosis receives the attention it should. These journals give to their readers accounts of recent work in terms sufficiently technical to be explicit, and, at the same time, phrased, so that they make interesting reading. Much good follows such advice. A too general and indiscreet publishing of medical facts culled by some journalistic Autolycus, by a hasty perusal of the medical journals, on the other hand, is not beneficial; it tends merely to add to the layman's "little knowledge," and makes this knowledge a "more dangerous thing." We do not suggest that the lay Press should assume a medical aspect—far from it—but what we strive to emphasise is that they should devote the space which they now give to such highly-seasoned paragraphs as "A Broken Heart Sewn Up," or "A Modern Rip Van Winkle," to short, explicit observations on the prophylaxis and mitigation of those diseases whose cause and course are influenced by such simple hygienic measures as may come within the scope of their readers.

WE congratulate MR. LEE ATKINSON on the interest which his paper, entitled "A Theory of Cancer,"—the prize paper of the Physical Society's last session, and which appeared in the pages of the GAZETTE of March 7th—has aroused. It was reprinted in full in the *General Practitioner*, and the comments which we have seen ought to be very encouraging, and repay, in some measure, the great amount of time and work which Mr. Atkinson must have devoted to his subject. It is seldom that a paper read before a students' society attains such an honour as to be reproduced outside its own hospital journal, and we are certain that all members of the society join us in hoping that the precedent set up will be followed in sessions to come by the further dissemination of those papers whose value should merit it.

ON another page will be found an article from the pen of Dr. Hertz on French Hospitals and Medical Schools. This article is to be continued, and alternating as it does with

Mr. C. L. Leipoldt's "Notes" from Berlin, which we published last week, and the second of which we have in hand, it gives the Gazette quite a cosmopolitan air. *Pari passu* with these, we see that the *Graphic* is publishing a series of articles on London Medical Schools, so that with a note or two from America and a communication from Italy and Russia, we will have the framework of a most comprehensive comparison of methods of medical education. Italy and Russia we have, promised; but American methods, won't one of our visitors send us a contribution? A comparison of these various curricula simply emphasises that which in London, and especially at Guy's, we are all so proud of, the real practical side. We venture to say, from what we have read and from what touring observers have told us, that nowhere is so much stress laid on the practical side of ward and casualty work—speaking of unqualified students, of course—as with us. The assistant surgeon's dresser, though he may silently curse the obstinate varicose ulcer and the clumsy strapping of his colleague in the Front, nevertheless finds a fund of experience which in after-life he will bless. It has been told of a certain dental diploma in one of our colonies that owing to the impossibility of procuring material—there is no medical school in the town—men learn their anatomy from books, and books only. One case we have come across. He knew the cranial nerves and their relations off by heart; he was shown the omo-hyoid, and asked what structure it was. His mental picture must have been most fallacious, for he answered, "That is the vagus nerve, isn't it?" No, though at times short firms, long hours, quick meals and hot days cause us to look harassed and worried, it is worth it, well worth it.

The Twenty-third Annual Report of the Guy's Institution for Trained Nurses proves interesting reading. It shows that the progress promised by past Reports is being well maintained. The high order of efficiency which marks the work done by the members of the Institution is a matter of pride to all of us, and we cannot too strongly emphasize the duty which every Guy's man who goes into practice should have before him, namely, to keep the Institution always in mind, and patronize it, and it only.

The paragraphs devoted to the work done by the Maternity Charity tell of some very sad cases of poverty and want amongst the patients, and it is good to turn to the long list of names of benefactors who, by gifts in kind or money, have contributed to the Maternity Samaritan Fund. No more worthy object of philanthropy exists, and many a poor deserving patient owes not only her own existence, but also that of her family, to the kindly interest which some nurse who has taken pity on her sorry plight, and been the means of obtaining warmth and succour for her at the very time when Nature demands it most. Now, you men of Guy's who are out in the world, and you who are still amongst us, you have met this poverty in your extern days, when your work takes you into the very midst of it all, and you recognize how cruelly genuine its existence is; therefore, interest your friends in it. Remember, any gifts are acceptable, food, cast-off clothes, old boots or linen, the smallest donation, they all help. They should be addressed to the Lady Superintendent of the Institution, 14, St. Thomas's Street, Boro', S.E. To anyone applying to this address, also, the Superintendent will be pleased to forward a copy of the last Report.

The Secretary-General, Professor Emile Grósz, gives notice that in connection with the sixteenth International Medical Congress to be held at Buda-Pesth from August 29th to September 4th, next year, there will be awarded a special prize of one thousand kronen for the best essay on "The Ætiology of Trachoma." Works, either in manuscript or published for the first time in 1907 or 1908, will be eligible if forwarded to the Minister of the Interior before December 31st, 1908. We notice that the officials of the English National Committee are Dr. F. W. Pavy (the President), and Dr. Rivière and Mr. D'Arcy Power (the two Honorary Secretaries). The address of the Secretaries is 10A, Chandos Street, Cavendish Square, W.

Dr. J. W. Eyre's lecture on Beneficent Bacteria, delivered at the Institute of Hygiene on Monday last, was well attended, and was followed by the greatest interest throughout. To many of the audience the fact that bacteria are not always pathogenic came as a pleasant surprise. Dr. Eyre described the *rôle* which micro-organisms now play in modern industry, how they are utilized in every-day commerce by the agriculturist, the cheese-maker, the tanner, the tobacco-blender, etc. We feel certain that many of the audience must have left the Hall with a feeling akin to pity for microbes generally, realising that they have been a much-abused body of organisms, and that, in the future, they will no longer think of them as mortal enemies, at all times to be cursed, but that only certain misguided species take on themselves the *rôle* of death-dealers.

Speaking of bacteria and their utility, it is interesting to review the growth of our knowledge of micro-organisms. In the seventeenth century, Galileo and Leuwenhock made incursions, by means of optical aids, into the "greater" and "lesser" worlds. The former—though really, in a sense, he was responsible for the invention of both the telescope and the microscope—chose to explore the great world above, leaving the infinitely minute on our own planet to the Dutch spectacle-maker. The Dutchman's discoveries were little enough in all conscience, but he had the true spirit, and, doubtlessly, paved the way. He entirely missed the relevance of his discoveries to disease, and though many writers, Linnæus, Lancisi, and others, were believers in the microbic theory of the origin of disease, and Plenciz, in 1762, even propounded, in a most precise and able manner, the modern theory, it was not until 1832 that any proof was forthcoming. This Bassi provided by showing the parasitic nature of silk-worm disease, and, in 1863, Davaine demonstrated what Pollender had suspected, the presence of the anthrax bacillus in the blood of human beings suffering from that disease. This was the first bacterium of human disease discovered; in quick succession others have followed, and, even now, we are just on the brink of true knowledge.

The *Hospital* of April 4th has nice things to say of Mr. A. R. Thompson's Hunterian Lectures, which lectures we hope to reproduce in these columns later. Mr. Thompson, as some of our readers will know, dealt in his first lecture chiefly with fractures about the neck of the femur, and very ably demonstrated the effect which the "calcar femorale" has in determining the extent and direction of these fractures. No one has before so clearly explained the *rôle* which this structure plays, and the lecture will do much to enlighten our knowledge. Amongst other things, Mr. Thompson suggested in the place of the old nomenclature, intra- and extra-capsular fractures—so misleading, since anatomically they are incorrect—a new phraseology, para-cephalic and para-trochanteric fractures. We wonder what sort of reception it will meet with.

The annual meeting and dinner of the Goblins Club will take place on Thursday, May 7th, 1908, at the Café Royal, Regent Street, W. Mr. H. T. Hicks, the president, will take the chair at 7 p.m.

Pass List.

University of Cambridge.—Degrees of M.B. and B.C. conferred: Captain T. C. Lucas, R.A.M.C.: also, Diploma in Public Health.

University of Durham.—M.B., B.S. Examination: J. F. Young. Anatomy, Physiology, and Materia Medica: E. W. Blake, G. E. Warner Lacey, H. F. Stephens.

March, 1908.

Second Conjoint Examination.—H. Daw, W. H. Talfourd Jones, W. E. Levinson, B. McDermott, P. J. Monaghan, T. T. O'Callaghan, C. E. Reckitt.

First Conjoint Examination. — Parts I. and II. (Chemistry and Physics): K. B. Clarke, J. S. Cocks, H. S. Groves, E. Lawrence Jones, K. J. T. Keer, E. M. Mahon, C. H. Medlock, A. V. Moberly, M. Pern, L. D. Wright. Part I. (Chemistry): H. C. Godding, H. D. Shore. Part II. (Physics): A. B. Danby, G. A. Pratt, M. H. Ratton, A. K. Selim, W. C. Whitworth. Part III. (Elementary Biology): K. B. Clarke, A. B. Danby, F. C. Godding, E. Lawrence Jones, J. L. D. Lewis, S. Wickenden. Part IV. (Practical Pharmacy): R. B. Dawson, H. W. Heasman, J. K. A. Helm.

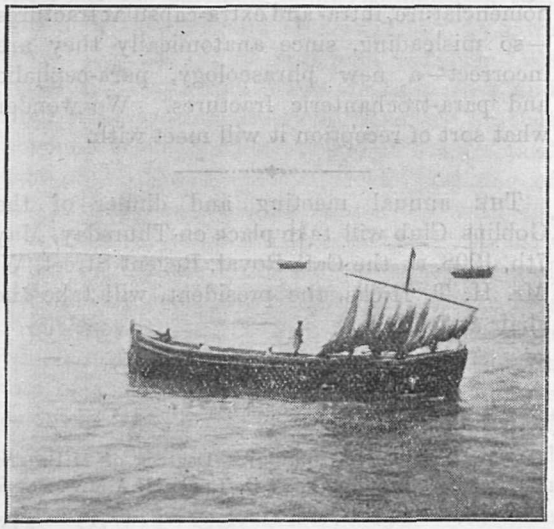
Licence in Dental Surgery.—Preliminary Science Examination: R. G. Farrington, *T. L. Fiddick, K. G. Hoby, F. A. Jaques, P. H. Orton, R. W. Powell.

* Chemistry only.

Tangier.

A Stroll through the Soko.

Tangier is a quaint city; it is, as it were, the portal of the East. So does it strike one who approaches it from Gibraltar across the Straits. Not that it has no Western aspect, for a few scattered European buildings, and in parts an installation of electric light, remind one of its proximity to the "enlightened" West. Unlike Algiers, there are no stately boulevards or gilded cafés; it is essentially more Eastern. Its Mosques, with their white domes and graceful minarets, are in striking contrast with the grim old Rock which, but a short space since, we left behind us.



An Arab Surf Boat near Tangier.

It is extremely cosmopolitan, and to stroll through the Soko, the huge market-place, is to see all phases of Moslem life. All the tribes of Northern Africa are there; here and there a few Europeans. This Soko is a veritable human kaleidoscope, and on a Thursday, when the caravans arrive from the interior, the bustle and noise beggar description. Here, a swarthy Moor and a diminutive Jew bargaining; here, a group of camels, kneeling, being relieved of their burdens; here, an awe-stricken crowd surrounds a favourite story-teller, as he—in what to us is a monotonous sing-song—tells of the mighty deeds of their ancestors, the conquerors of Spain.

Close by sits a snake-charmer and his assistant, who with weird incantations and mystic passes, plays with these venomous reptiles. He is quite famous; all visitors to Tangier must have seen him. From a sack he produces a snake about three feet long, which he hands to his assistant, who takes it around and exhibits its fangs, seemingly intact, to the bystanders—a biologist of my acquaintance assured me it was of a most deadly species. The charmer then takes the reptile in his hand and holds it on a level with his mouth, the while repeating his shibboleth and gently stroking the animal. Suddenly he projects his tongue; at the same instant out darts the fang of the snake, and a tiny red spot appears on the charmer's tongue. The snake is pushed away, unceremoniously, into the sack by the assistant, who has, in the meantime, been beating a tom-tom, and chanting in a most unmelodious manner. The master then displays the tiny bleeding puncture on his tongue, and picking up a handful of straw, he places it between the palms of his hands and blows on it. Presently a slender wreath of smoke is seen ascending from the straw, which gradually increases in volume till the whole is ablaze, and he throws it down. This latter piece of legerdemain is, probably, comparatively simple to explain; but what of the snake-bite itself? Is this man immune, or is the snake powerless to secrete the necessary venom? Maybe it has been extracted before. Nevertheless it is an interesting performance.

Snake Charmer and Assistant.—The snake biting his tongue.

Another artist in his way, is the clairvoyant, who reads one's future in the sand. His demeanour is most impressive, and many stories have I heard of his prophecies being more or less realized.

Constantly, on all sides, one hears strident cries of "Balak" (look out), as a poor overburdened mule or a string of camels push their way through the crowd. No rule of the road here; the pedestrian makes way for the equestrian; a mighty "Balak," and you hastily jump aside.

As the night falls, you might be fortunate enough to meet a Moorish bride being conducted to the bridegroom's house. This is a most impressive sight, and is carried out with great éclat, and much noise. In front of all come men with tom-toms, and maybe an acrobat or two (this

to amuse the crowd), then comes a body-guard of stalwart eunuchs, folowed by several female slaves grouped about the palanquin bearing the bride. The palanquin is borne by four lusty negroes, the bride sits within, heavily veiled.

No man—granted she is being married for the first time—except her father and brothers, have ever set eyes on her face, not even the bridegroom himself; he has signed the contract of marriage, but not until to-night, in the bridal chamber, will he be permitted to see his wife unveiled.

Surrounding the Soko, on all sides, are innumerable cafés, and as the Prophet forbids alcohol, these are cafés in the literal sense of the word. In the higher-class ones, one often meets coteries of middle-class Moors, who are fond of assembling together, either to discuss some point in the Koran, or, as more usual, commercial affairs. On occasions they indulge in music, which of course is essentially Eastern in character. Tom-toms, cymbals, and a stringed instrument serve to accompany the chanting of

Principal Street in Tangier.

a song, usually an Epic, dealing with their ancestors in Spain, or else a set of verses of one of the Arabian poets. Each tribe seems to have a favourite rendezvous, and many of the cafés cater for special sects. Tangier has one place of amusement, unmistakably European, a music-hall, and the cinematograph thereat was a source of no little wonder to the natives.

Yes, the Soko is an interesting field for the student of humanity; its colouring, its noise, its whole aspect is undeniably fascinating. A. L. V.

Change of Address.

W. C. Ball, Esq., B.A., from 48, Bovill Road, Honor Oak Park, S.E., to 2, Keston Villas, Keston, Kent.

Mr. E. L. Pilbeam, L.D.S., from Barberton, Transvaal, South Africa, to 31, Southdown Avenue, Brighton.

Dr. H. J. Roberts, from the Neuk, 71, Whitehall Park, N., to "Upwey," Ventnor, Isle of Wight.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Present to Mr. Prestage.

Sir,—You were good enough to insert, a few weeks ago, a note from me suggesting that a little present should be made to Mr. Prestage, the late Head-Porter.

I have received, in all, various subscriptions amounting to £25 2s. 6d., which has been sent to Mr. Prestage, and I would ask the favour of your printing his reply.

The names of the subscribers have been sent to Mr. Prestage with the money.—Yours faithfully,

Counting House, HENRY WILLIAMS,
Guy's Hospital, April 10th, 1908. Clerk.

41, Murillo Road,
Lee, S.E.
April 12th, 1908.

Dear Mr. Williams,

Father wishes me to write and thank you for your kindness to him.

Will you please, as far as you can, thank the gentlemen who have contributed.

Father is still very poorly and not able to leave his bed, but we still hope that he will be able to enjoy his well-earned rest for some years yet.

With kind regards from Mr. and Mrs. Prestage.

Yours truly,
E. PRESTAGE.

H. Williams, Esq.

Some Reflections from an old Guy's Man.

When I first started to practise in Mentone a French doctor told me there were three essentials to success—

Savoir, Savoir-Faire, and Faire-Savoir.

which I interpreted as meaning (1) knowledge of one's profession; (2) the capacity of making the best of one's knowledge and opportunities; and (3) the faculty of producing a good impression on others. My French confrère maintained that the last was the most important, but my belief then, and since, has been that they form, like three legs to a table, essential supports to any man who would really succeed in medicine.

If one could compare the relative value of three equally important things, I should say that *savoir-faire* was most to be desired. *Savoir* can be largely acquired at Guy's Hospital; *faire-savoir* may be partly assumed and gradually cultivated; but *savoir-faire* is almost a gift of the gods.

One of the first cases to which I was called when acting as a locum tenens, after leaving Guy's, was of this

sort: The patient, a lady, was apparently in much pain, it was supposed from acute peritonitis. Her husband and two grown-up daughters were at the bedside in great distress and anxiety. I examined the patient, and the *savoir* with which I was equipped at Guy's told me that there was no peritonitis at all, and really probably nothing the matter. My private diagnosis was that she was suffering from the rebound, after a family quarrel. Had I then said she was well, I should have drawn on her the anger of the whole family, and on myself her perpetual hate. Had I said there was peritonitis, or other serious malady, she would have thought me a fool, knowing herself she was shamming; consequently I used what *savoir-faire* I had to make peace all round.

In my experience a large proportion of one's most important work is directing into their proper channels the lives and energies of one's patients, and controlling their relatives and friends. It is important to spot why a patient wants to go to Scarbro' when the sister says Whitby, or to Brighton when the aunt urges Bournemouth. Sometimes a special friend of the opposite sex is already there, or a pet doctor, who has cultivated *faire-savoire* to the neglect of all else.

Take another case. You are called to see a contagious malady in a large hotel. First you must recognise it, but almost more important is to know at once how to manage it. A little muddling, and, instead of helping the hotel manager and the family out of a difficulty, you increase their troubles, and prejudice them against you, perhaps for ever.

All this is obvious, but the third gift of *faire-savoir* must not be overlooked. How many excellent and able men cannot make others believe in them, or be enthusiastic over them. They are untidy, careless, or unbusinesslike; or perhaps they are lacking in self-restraint or self-assurance, so that an inferior man produces a better impression. Their store is stocked with goods, but there is little or nothing in evidence, and, though well able to do their duty to others, they fail to do their duty to themselves. Charles Spurgeon told his students that when they had nothing to say they should know how to say it. Much more, when a doctor has knowledge and capacity, he should see that his gifts are not hidden treasures, trampled under foot by the unwary. The fools of the world—and they, perhaps, predominate—are largely caught by surface impressions, and a wise man cannot shut his eyes to the fact without injustice to himself and injury to others.

It is by holding this trinity in unity, exalting none at the expense of the other, but properly combining them all, a man is, in my opinion, likely to make a success in life, and especially to prosper in the medical profession.

D. W. S.

At the prize distribution on April 6th, by Sir Dyce Duckworth, at the Royal Naval Hospital, Haslar, Surgeon Geoffrey Carlisle, R.N., was awarded the prize for Tropical Medicine, a microscope. Mr. Carlisle received the highest aggregate of marks, 4,468, obtained at both the London and Haslar examinations.

In Lighter Vein.

Gastric Lavage.

Lavage of the stomach for chronic and painful disorders of that organ without pyloric occlusion is often spoken of, but seldom, or at any rate too seldom, actually resorted to. The following letter shows what good it can do. The patient was a man over fifty years of age, who had long baffled all medicinal treatment for symptoms which suggested old ulceration of the stomach, or chronic dyspepsia. He required only two lessons in passing the tube before he was able to use it himself without any difficulty. He writes:—

April 4th, 1908.

Dear Doctor.—I take the liberty of dropeing you a few lines to let you know that I have now concluded My six weeks Process off washing out for my stomach trouble, and I am very glad to inform you that it has been A grate Success. I feel altogether A New Man Now, and in Normal Condition again. the pain has left My Stomach Now, that use to give Me trouble at Night, and Keep Me from Sleeping. I still take a wash out Now, and Again. if I over indulge in heavy Meal's, and leve a sourness in My stomach. but the wash out Makes Me all right again. I keep preety regular on My Irish Stew (as you recommended) and have it at least four times a week. I also have a few biscuits at My bedside, which I take in the night time if I wake up. that also helps me if the wind is trublesome. I am inclined to belive, Doctor, that their is No ulcer in My Stomach, or if their is the washing out has put it to Sleep, for a time at least, and I hope forever. their has Never any Blood come up with the washing out, and whatever blood came up before Must have been caused by reaching, and straining when vomiting. I shall just keep on as I am doing. regulate My Meales as best aggree's with Me. take a wash out now and again, with a dose of opening Medicine im between. if you have any cases like Mine Doctor, dont hesitate in giveing them the wash out cure. I can Highly recommend it

Hopeing this finds you in good Health

I remain yours faithfully

G—— D——.

Some Notes on Cataract Extraction.

CLINICAL LECTURE BY Mr. ORMOND.

Gentlemen,—I wish to-day to bring before you certain points in the consideration of the treatment of cataract which are not, as a rule, dealt with in any detail in your text-books; and to give you some idea of the average results of operation for cataract, Mr. Bergin, my clinical assistant, has kindly helped me by tabulating the results of fifty consecutive hospital cases on which I have operated.

The name cataract, as applied to a condition of the eye, dates from mediæval times, and was derived from the idea that the interference with vision, which is always present, was due to a plastic effusion falling over in front of the lens, there being a supposed similarity in effect between that and the opaqueness of water falling over rocks. This idea remained dominant until 1705, when Brisseau read a paper before the Royal Academy of Medicine in Paris, in which he demonstrated that the opacity was in the lens itself. By cataract, then, we mean an opacity of the lens, and this opacity may involve the whole lens or only part of it; it is quite erroneous to give the name of cataract to any opacity other than that involving the lens or lens capsule; corneal opacities are very frequently designated by the laity as cataracts.

The lens is situated, as you know, behind the iris, and is a bi-convex body, the posterior surface being more convex than the anterior. The lens is suspended from the ciliary body by the suspensory ligament in such a way that all rays of light passing through the pupil must pass through the lens; should there then be any interference with the perfect transparency of the lens, it will affect the transmission of light rays to the retina, which will, of course, mean an interference with vision. This, then, indicates to you the main symptom of a cataract; there are other symptoms, such as monocular diplopia, or polyopia, the presence of specks in front of the eyes, and an alteration in the visual acuity depending upon the intensity of light; but the main symptom which is universally found in all cases of cataract is the gradual progressive failure of sight. There is no inflammation, neither is there any pain, and the duration of the case varies considerably. I am speaking to-day only of senile cataract, and it is unusual for senile cataracts to develop before the age of 45, the average age being 55—60. In the cases before you, you will notice that the youngest, which is exceptional, is (No. 38) æt. 33, and the oldest is (No. 3) æt. 76. It is obvious then, that the loss of vision caused by the opaqueness of the lens must be remedied by the removal of that body, and in cases of senile cataract operative treatment alone is possible, as we have no knowledge of any drug or any substance which has the power of dissolving a lens the nucleus of which has become hard.

The lens consists of three parts—the capsule, which envelops all the lens substance, a central hard portion, called the nucleus, and, between the nucleus and the capsule, a softer portion, called the cortex. The lens varies in size in different people; the relationship between the size of the nucleus and the cortex also varies, but this anatomical division is always present.

It must be clearly understood that what we in England mean by cataract extraction is the removal of the nucleus and cortex from within the capsule, the capsule remaining within the eye. It is a fact that some ophthalmic surgeons, notably those working in India, where cataract is much more prevalent, have recently published long series of cases in which the lens has been removed in its capsule, but such treatment has not become common practice in England, owing to the increased risk of damaging the eye during the extraction.

A cataract may be partial or complete; in the earlier stages only portions of the lens are opaque, and whilst this is so, the lens should not be touched, such a condition of things being spoken of as immature, or unripe cataract When, however, the opacity involves the entire lens, the cataract is ripe, and when in that condition is more easily removed.

The signs of ripeness are :—

1. The absence of the iritic shadow.
2. Absence of the red "reflex."
3. The reduction of the vision to mere perception and projection of light.
4. The depth of the anterior chamber, which should be normal.
5. The absence of bright shining sectors in the lens itself.

There are, of course, some occasions when it is advisable to remove an unripe cataract, but I am not dealing with such cases to-day.

It may happen to you to have to give an opinion as to the probable result of an operation on an eye which you have not had an opportunity of examining previously, that is to say, before the retina and choroid were hidden by the opaque lens; you may obtain much valuable information by examining the eye, and ascertaining, firstly, if the pupil reacts to light; secondly, if the eye can perceive and project light in all parts of the field; such an examination will help you to decide as to a patient having optic atrophy, extensive choroiditis, or detachment of the retina, which, if present, would preclude a first-class result. In the cases before you, you will find several in which such a condition was ascertained before operation, but the operation was done, in those instances, in the hope of increasing the small amount of sight which the patient possessed, as, for example, cases 4, 44, and 49.

Having decided to operate, the greatest care must be taken to see that there is no possible source of infection within the conjunctiva. Pressure should be made over the lachrymal sac, to see if any regurgitation takes place from the canaliculus; the upper lid should be everted, and the fornices thoroughly examined, in order to see that no flakes of mucus are present. The day previous to the operation, a purge should be given to the patient, as any straining at stool for the first three days is inadvisable. A thorough cleansing of the skin of the face with soft soap and perchloride of mercury is advantageous if performed shortly before the operation. No general anæsthetic is necessary, and should be avoided, unless the patient has no self-control; cocaine of a strength grs. v. ad. ʒi., *i.e.*, 1 per cent. instilled into the conjunctival sac three or four times, at intervals of five minutes immediately previous to the operation is usually sufficient to anæsthetize the eye. The only instrument absolutely essential is a Graefe's cataract knife, and I have seen a cataract successfully removed with this one instrument, but this should only be undertaken by an expert operator. The other instruments which are usually employed are a speculum, fixation forceps, iridectomy forceps and scissors, and a cystitome. Personally, I prefer to have my patients in bed while I operate, as it is desirable to move the patient as little as possible after the operation; to facilitate this we have, in the wards, specially designed beds.

The conjunctival sac should be thoroughly washed out with warm boric lotion immediately before commencing. The actual steps of the operation you will find more or less fully explained in your text-books, but there are a few points to which I want to draw your attention.

Should a conjunctival flap be made? If a preliminary iridectomy has been performed, or you intend to make an iridectomy at the time you extract, the incision should be so arranged that a conjunctival flap is formed, the advantage being that the wound is closed in twenty-four hours. If, however, you intend a simple extraction, the incision should be started at the corneo-scleral junction as usual, about the level of the point where the upper and middle third meet, and the knife should be carried forward so that it cuts out through the cornea. This incision diminishes very considerably the risk of a prolapse of the iris.

There are in practice three different methods of procedure in extracting a cataract.

Some surgeons perform the operation of iridectomy separately, and allow the wound to heal, not proceeding with the extraction until a month or more has elapsed, thus making two separate and distinct operations. Some, on the other hand, perform an iridectomy and remove the lens at the same time, whilst others remove the lens through the pupil and do not perform an iridectomy at all. In the list you have before you, where it is stated that a preliminary iridectomy was performed, the first procedure was adopted, the second where iridectomy and extraction are mentioned, and the third where the simple extraction is recorded.

Whether or no an iridectomy should be performed cannot be answered directly in the affirmative or negative; to decide the question we must consider each case separately on its own merits. The main reasons advanced by the advocates of iridectomy for the faith that is in them are: 1st, it is easier to deliver the lens; 2nd, that prolapse of the iris is not so likely to occur;

3rd, any tendency to glaucoma is forestalled; 4th, there is no necessity to keep the patient so long in bed.

On the other hand, the advocates of simple extraction say that the cosmetic effect is poorer; 2nd, it is a needless mutilation; 3rd, the "stop action" of the iris is lost; 4th, the vitreous is not so well retained.

It is sometimes impossible to deliver a large cataractous lens through the pupil, and then an iridectomy must be done. It is certainly easier and safer to perform an iridectomy before delivering the lens, and I usually do so where, for any reason, the most guarded course is imperative, such as in a case where a patient has only one eye; on the other hand, there is not the slightest doubt that the successful removal of the lens through the pupil, when feasible, is the operation which gives the most completely satisfactory result, and the most perfect operation should always be aimed at by the operator.

The operation of needling takes place some time after the removal of the lens in those cases in which it is necessary, and consists of tearing a hole in an opaque membrane which forms behind the iris, in front of the vitreous. This is often designated "secondary cataract." After the lens has been removed, the epithelium on the posterior surface of the anterior wall of the capsule proliferates and forms fresh lens fibres, which turn opaque, and, being enmeshed between the anterior and posterior walls of the empty capsule, form this grey opaque membrane.

Let us now consider the list which you have before you. You must understand that these are not picked cases, but they have been taken consecutively from amongst my in-patients, and, in many instances, the eyes had been previously affected by other diseases, as in Nos. 3, 8, 13, etc. In other patients, the defect of the light reflex, and of perception and projection of light precluded a first-class result, but in most of these cases the patients were benefited by the small addition to their vision, which the removal of the cataract secured for them, and you must remember that, amongst nearly blind people, the power of distinguishing light from darkness is a very great consolation, and if this can be increased to perception of large objects, the gain in independence to the unfortunate sufferer is incalculable.

All operations on cataracts may be looked upon as successes where the patient sees better after the operation than before, but a surgeon would not be satisfied with his result in an uncomplicated case unless the patient, with proper glasses, were able afterwards to read ordinary print. If a patient's vision is equal to or better than 6/18, he can attain this. Fortunately, it is not uncommon to obtain a very much better result than that even, as in cases 2, 16, 25, 29, 33, 37, 38, and many others.

You notice that all the cases subsequent to operation require a high convex lens, which is equal to about + 11 or + 12 diopters. The lens in a case of cataract has been found to be equal to about + 12 D, so that when it is removed from within the eye this strength lens must be replaced. For reading, a lens of from 3 to 4 diopters must be added to this, so that, if a patient sees in the distance with a + 12, he will require a + 16 for reading. In addition, you will notice that a large proportion of the cases were ordered a cylindrical lens of from $1\frac{1}{2}$ to 2 diopters, as in cases 2, 9, 10, 12, 17. This astigmatism was produced by the incision, and its axis is always at or near the horizontal.

When a patient has suffered from iritis at some time previous to the operation, the inflammatory reaction (which in uncomplicated cases is usually slight) is often violent and prolonged. In some cases this subsides and good vision is obtained; in others a chronic irido-cyclitis results which gradually destroys sight, as in cases 8 and 28. The onset of irido-cyclitis one or two months after the operation in cases which otherwise have followed a normal course, is another misfortune which sometimes attends cataract extractions. In these patients I have sometimes found evidence of chronic arthritis in the hands, feet, etc., and I think these cases are probably secondary cataracts, since the inflamed ciliary body is unable to provide for the nutrition of the lens, which turns opaque, the operative interference aggravating the cyclitis. Such a condition is often not suspected before operation, as the patients present themselves with fully matured lenses, and the diagnosis could only be made in the early stages. This partly accounts for the percentage of failures in hospital cases being higher than in private practice, where patients usually seek advice earlier.

In conclusion, we may say that the present-day operation for removing a cataract is not a severe one, necessitates no great demand upon the patient's strength, and is generally successful—from a surgical point of view almost always; the failures being more often due to disease of the uveal tract than to the operation.

50 CONSECUTIVE HOSPITAL CASES.

No.	Initials.	Age.	Eye.		1—6 months. Early result.	6 months and after. Late result.	Remarks.
1	C. P.	50	L	Pre. Idy. Extraction. Needling	c+12 = $\frac{6}{12}$	c+12 = $\frac{6}{12}$	
2	D. D.	48	L	Pre. Idy. Extraction. Needling	c+13 / 1·5 D & O = $\frac{6}{6}$		Patient had sugar in urine
3	W. L.	76	R	Extraction and Idy. Needling	c+11 / +2 horiz. = $\frac{6}{36}$	c+12 / +2 horiz. = $\frac{6}{24}$	Patient had chronic bronchitis and floating vitreous opacities
			L	Pre. Idy. Extraction	c+13 = $\frac{6}{24}$		
4	A. F.	38	L	Pre. Idy. Extraction	No improvement		Detachment of the retina existed and was suspected before op.
5	J. B.	58	R	Extraction and Idy.	c+10 = $\frac{6}{18}$	c+10 = $\frac{6}{18}$	
6	M. P.	53	L	Pre. Idy. Extraction. Needling	c+9 / +2 horiz. = $\frac{6}{12}$ Wound healed, result satisfact'ry		Not seen subsequently.
			R	Pre. Idy. Extraction			
7	T. U.	36	R	Simple extraction. Needling	c+11 = $\frac{6}{18}$	c+10 = $\frac{6}{18}$	
8	T. G.	65	R	Extraction and idy.	c+10 = $\frac{6}{60}$	Irido-cyclitis. Vision reduced to P. L.	Patient had numerous attacks of irido cyclitis both before and after extraction.
9	W. B.	69	L	Simple extraction without Idy. Needling	c+8 / +2 horiz. = $\frac{6}{36}$	+11 = $\frac{6}{24}$	Patient had an attack of iritis after operation. Patient still using his right eye, which has vision $\frac{6}{12}$
10	W. H.	69	R	Idy. Extraction. Needling	c+13 / +2 horiz. = $\frac{6}{12}$	$\frac{6}{12}$ same glasses each eye	Idy. was performed on account of suspected glaucoma.
			L	Prs. Idy. Extraction. Needling	c+13 / +1·5 = $\frac{6}{24}$		
11	C. W.	60	R	Simple extraction. Vitreous escaped before lens, which was extracted with a hook.	Could count fingers	Not seen subsequently	A month after operation a note was made, "Wound closed, pupil clear, vision = counts fingers. Doing well."
12	L. G.	72	L	Attempted extraction without Idy. Idy. and extraction	c+10 / +1·5 horiz. = $\frac{6}{9}$	$\frac{6}{9}$ c glasses	
13	E. E.	72	L	Pre. Idy. Extraction	c+6 v. = less than $\frac{6}{60}$		Extensive choroidal atrophy extending from disc to macula, otherwise result of operation quite good. Right eye also had choroidal changes.
14	R. A.	70	R	Pre. Idy. Extraction	c+10 / +2·5 horiz. = $\frac{6}{24}$	c+12 / +2 D & O = $\frac{6}{12}$	

No.	Initials.	Age.	Eye.		1—6 months. Early result.	6 months and after. Late result.	Remarks.
15	S. R.	65	L	Extraction with Idy.	c+6 = $\frac{6}{12}$		Patient was myopic.
16	W. S.	74	R	Pre. Idy. Extraction	c+8 / +1 horiz. = $\frac{6}{9}$		
17	J. S.	64	L	Extraction with Idy.	c+12 / +2 horiz. = $\frac{6}{18}$		Patient had glaucoma in the right eye and dislocated lens.
18	W. S.	74	R	Extraction with Idy.	c+13 / +1·5 horiz. = $\frac{6}{36}$	Patient had attack of iridocyclitis in the following year	Patient not seen subsequently.
19	C. J.	63	R	Extraction with Idy. Needling	c+9 / +2 D & I = $\frac{6}{18}$		
20	J. C.	67	R	Pre. Idy. Extraction. Needling	c+12 = $\frac{6}{12}$		
21	E. P.	70	R	Simple extraction	c+11 = $\frac{6}{12}$		
22	S. B.	68	R	Simple extraction. Needling	c+12 = $\frac{6}{18}$		Patient had choroiditis in left eye.
23	A. B.	67	R	Extraction with Idy.	c+12 / +2 horiz. = $\frac{6}{18}$		Patient moved during operation and iris was torn.
24	M. H.	75	L	Extraction with Idy. Needling		Left eye subsequently shrank following chronic iridocyclitis	During convalescence patient received severe blow on the eye.
25	D. S.	70	L	Simple extraction. Needling	c+13 = $\frac{6}{18}$	c+14 = $\frac{6}{9}$	
26	J. W.	64	R	Simple extraction. Subsequent prolapse of iris. Wound healed. Idy. with needling later	c+10 = $\frac{6}{36}$	c+10 = $\frac{6}{18}$	
27	M. V.	52	R	Extraction (Simple). Needling	c+11 = $\frac{6}{24}$		Patient attended for two months, and then returned to Cornwall. Has not been seen since.
28	T. C.	62	L	Simple extraction			Chronic irido cyclitis followed, and the eye gradually atrophied.
29	W. V.	52	R	Simple extraction	c+10 = $\frac{6}{9}$		
30	S. W.	51	R	Pre. Idy. Extraction	c+12 = $\frac{6}{12}$		The cataract was a traumatic one.
31	C. H.	65		Simple extraction	c+12 = $\frac{6}{60}$	Can read large print	Has mitral disease Not seen after first six months
32	A. C.	61		Simple extraction attempted. Idy. performed on account of largeness of lens. Needling.	Good ?		Patient died from cerebral trouble shortly afterwards.

No.	Initials.	Age.	Eye.		1—6 months. Early result.	6 months and after. Late result.	Remarks.
33	D. H.	70	L	Extraction and Idy.	c+10 = $\frac{6}{18}$	c+10 = $\frac{6}{18}$	Corneal opacities, l. e.
			R	Simple extraction	c+11 = $\frac{6}{18}$	c+10 / +1 horiz. = $\frac{6}{6}$	
34	D. M.	62		Simple extraction	c+10 / +2·5 horiz. = $\frac{6}{6}$		
35	H. B.	69	R	Simple extraction attempted. Idy. and extraction	c + 12 = $\frac{6}{60}$?	Patient could see fine stitches	Patient had severe iritis for some weeks after op. Patient was illiterate
36	H. R.	49	R	Simple extraction. Needling	Time by watch	c+ 9 / +1·5 horiz = $\frac{6}{9}$	
			L	Simple extraction. Needling		+10 / + 2 horiz. = $\frac{6}{9}$	
37	F. B.	49	R	Simple extraction		c+9 = $\frac{6}{6}$	
			L	Simple extraction	c+11 = $\frac{6}{18}$	c+10 = $\frac{6}{6}$	
38	J. D.	33	R	Simple extraction		c+10 = $\frac{6}{6}$	
39	A. D.	58		Simple extraction		c+14 / +1·5 horiz. = $\frac{6}{9}$	
40	S. L.	56		Simple extraction		c+12 = $\frac{6}{9}$	
41	M. H.	50		Extraction with Idy.			Had previously had iritis. Extensive choroiditis found after operation.
42	G. F.	57	L	Extraction with Idy.	Suppuration	Evisceration of eye	This was a case of old interstitial keratitis and iritis.
43	D. K.	56		Simple extraction	c+14 = $\frac{6}{12}$		
44	M. L.	72		Extraction and Idy. Needling	Hand movements		Projection was bad before operation.
45	J. K.	66	R	Simple extraction	c+11 = $\frac{6}{18}$		
46	M. R.	72	L	Pre. Idy. and extraction	c+8 / +3 horiz. = $\frac{6}{36}$	+13 / + 2 horiz. = $\frac{6}{9}$	
47	M. C.	78	L	Simple extraction followed by Needling	Can see to go about quite well		Owing to feeble condition of patient, wound did not heal till over one month after operation. Extensive choroiditis found after operation.
48	O. P.	43	R	Simple extraction	c+10 / + 2 horiz. = $\frac{6}{9}$		
49	W. B.	57	R	Simple extraction. Needling	Hand movements		This patient was known to have diseased fundus, perception and projection of light bad before operation. Dissem. choroiditis found. Died one month after operation from aneurism.
50	E. W.	42	R	Simple extraction. Needling	c+12 = $\frac{6}{12}$	+12 = $\frac{6}{9}$	

Aspects of French Medicine.

By Dr. Hertz.

I.

In October, 1906, on my return to England after a year spent in Germany, I described some of my impressions in a paper written for the Gazette. In it I spoke of the unfortunate manner in which the advances made in medical science in England and in Germany are to a great extent mutually ignored. Three months recently spent in Paris have shown me that, in spite of the *entente cordiale* and its offshoot the *entente cordiale médicale*, this is equally true in the case of France. French physicians for the most part wholly disregard the work done in both Germany and in England, but especially in England, and on the other hand much of the most valuable recent medical research carried out in France is too little known and appreciated in England.

In this paper I shall try to present some idea of the condition of medical science in France at the present day. As it is always interesting to be able to compare our English hospitals and medical schools with those of other countries, I shall also give some account of French medical institutions so far as I was able to study them in the short period of three months.

In France the provincial medical schools outside Paris are of comparatively little importance. This is in sharp contrast to the conditions in Germany, where the schools of Munich, Heidelberg, Strassburg, Leipzig, and many others, are each important centres of medical activity, which are only inferior to that of Berlin in actual size. The provincial medical schools of France are, I believe, similar to the Paris school in general features, so that the following account, which is derived from what I saw in Paris, can be looked upon as descriptive of French medical institutions in general.

The hospital and its staff.—The majority of Parisian hospitals are inferior in every way to those of London. Very little has been done in most of the older ones in order to bring them up to date. There are, however, some notable exceptions. The Hôtel Dieu, which dates from the ninth century, has been rebuilt in an admirable manner, and in general arrangement now resembles St. Thomas's Hospital. The old buildings of the Cochin Hospital are gradually being replaced by excellent new ones, but meanwhile much good work is being done in buildings which are hardly fit for human habitation. The hospitals of more recent foundation are, on the whole, well designed, but there seems to be a tendency on the part of the Assistance Publique, the State Department which owns and controls all the hospitals, to spend insufficient money on their construction. The wards are generally very gloomy in comparison with those of English hospitals. The contrast is no doubt due to the governors and friends of our hospitals being represented in France by underpaid servants of the Republic. The wards are almost always named after distinguished French physicians and surgeons, though a number of hospitals have also a Lister ward. The custom certainly seems more sensible than the common one in England of searching the Bible instead of the hospital history for suitable names.

Although most Parisian hospitals are very large, they are almost invariably overcrowded. The cubic air-space and the number of beds which each ward is meant to contain are in some hospitals painted over the doors. It is rare, however, to find the number adhered to, extra beds of inferior pattern being put between those originally intended for the ward, and one or two rows of beds being frequently arranged down the centre. Thus one ward, of 1,116 cubic metres capacity, was constructed to hold twenty-two beds, but on my first visit to it I counted forty-four beds, and the next day I found five more had been added. In this crowded ward there were two patients with typhoid fever and about a dozen with advanced phthisis. The hospital staff is quite unable to remedy this state of affairs; it is due to the slowness with which the lay authorities realize the necessity of providing Paris with increased hospital accommodation.

The value of fresh air in all classes of cases is as little appreciated in France as in Germany. During the winter it is quite unusual to find a single window open in the wards. As they are also so overcrowded, the state of the air in them is often most unpleasant. This is no doubt largely due to the fact that the average Frenchman is happiest under atmospheric conditions which are very trying to the average Englishman. Thus the air in French theatres is so close that it is difficult for an Englishman to remain awake to the end of a play, however excellent the acting may be.

Though I believe that the food supplied to the patients is good, it is prepared in an exceedingly unattractive form, and the unappetising way in which it is served is surprising to see in a country where the importance of the mental factor in the treatment of disease is so widely recognised.

Until a few years ago, all the nursing in French hospitals was in the hands of religious sisters. They were not, as a rule, well trained, but they looked after the patients to the best of their ability and kept the wards scrupulously clean. Some may have been too much concerned with the welfare of the souls of those entrusted to their care and neglected to some extent the nursing of their bodies; but they gave up their lives without material recompense to the care of the sick, and whatever they lacked in knowledge of the science and art of nursing they made up by their untiring devotion to duty. Now, unfortunately, all is changed. Since the disestablishment of the French Church the religious sisters have been gradually replaced by lay nurses. During the past winter the change was completed by the dismissal of the nursing sisters from the Hôtel Dieu, where, for nearly a thousand years, successive generations of *religieuses* had devoted their lives to the care of the sick. The new nurses are the servants of the Assistance Publique. They are badly paid, and the majority have to live outside the hospital. They come solely from the lower strata of society, as it is unheard of in France for ladies of good family to become nurses. The training received by the nurses is most superficial, and, as a consequence, the nursing is very inferior to that of England. Their costume consists of an overall, made of a kind of sacking, which effectively hides any charm the wearer may possess.

From what has been said about the internal arrangements of the hospitals, it can easily be understood that they are not popular, and that the majority of people dislike the idea of entering a French hospital as much as the London poor dislike the workhouse infirmary.

The hospital staffs are appointed by the Assistance Publique, after competitive examination. A successful candidate is appointed physician, surgeon, or specialist of some sort, "to the hospitals of Paris." At first he is unattached and has to do holiday work at various hospitals. Later he is appointed to some hospital without much regard to his own wishes and without previous consultation with his future colleagues. If a physician in charge of out-patients is promoted, he frequently receives beds in a hospital with which he has not previously been connected.

The infirmaries and hospitals are under the same control, and their staffs are selected from the same class of men. The appointment of physician to the two celebrated infirmaries, the Salpêtrière and the Bicêtre, each of which is a small town in itself, with between three and four thousand beds, is much sought after by neurologists. The nerve cases are collected in special wards, where they can be conveniently studied, the remaining patients being crowded in the rest of the building, where they seldom receive a medical visit. As a consequence of this arrangement, the vast material for the study of chronic nervous diseases, which is lost in the infirmaries of England, is thoroughly utilised in Paris. It is possible to watch the course of such chronic diseases as disseminated sclerosis or tabes from the onset until death, and then compare the post-mortem findings with the record kept of the clinical symptoms. Patients suffering from the rarer nervous diseases, examples of which are only seen at long intervals at English hospitals, are taken into the Salpêtrière or Bicêtre, where they remain until death, so that these infirmaries offer unique facilities for the study of every variety of disease of the nervous system. Autopsies are not infrequent at the present day at the Salpêtrière on patients whose clinical histories had been kept for many years by Charcot himself. There are often as many as three or four post-mortems a week in these institutions on patients who have suffered from nervous diseases. Within two hours of death 150 cc. of 50 per cent. formalin are injected through the cribriform plate into the cranial cavity, and twenty-four hours later the hardened brain and spinal cord are removed. The physician subsequently makes a preliminary examination of the nervous system, and if anything of special interest is found, a more complete anatomical investigation is made under his direction by one of the numerous students, who are always anxious to do such work for M.D. theses, as no medical degree is given in France after examination alone. Material for instruction in nervous diseases being so abundant, an excellent opportunity is given to the students of learning their clinical features. On one occasion, for example, I saw eight cases, illustrating the different varieties and stages of disseminated sclerosis, demonstrated in a single clinical lecture.

Each member of a hospital staff has an *interne* and a varying number of *externes* attached to him. They are all unqualified and appointed by the Assistance Publique after examination. The physician with his interne and externes visits the wards during the morning. He dictates the treatment to the sister, who writes it down in a notebook without any supervision. This system seems to be somewhat dangerous, as the education of the sisters is little if any higher than that of the ordinary nurses.

In-patients are distributed in the different wards in such a way, that a physician specially interested in any one class of disease has a large proportion of such cases under his care. This specialisation is, however, yet more marked in the out-patient departments. At many of the hospitals there are special days for seeing patients suffering from diseases of the heart, the lungs, the alimentary canal, and the nervous system as well as for skin diseases and diseases of children, it being apparently left for the patient to decide which of his organs is affected.

There is thus much more specialisation in medicine in France than in England, and there are consequently fewer general physicians, with the result that the general standard of clinical medicine in France is distinctly lower than in England.

The medical schools and the students.—In spite of the attractions of Paris, the life of the average medical student cannot be as pleasant as that of his London compeer. From the time of his matriculation until he qualifies he may never be attached to any hospital. Even if he becomes an *externe*, he rarely follows the practice of any hospital for more than four months. Thus he never gets really interested in his hospital, and *esprit de corps* is impossible. There are no hospital sports or clubs, and there is nothing to compare with the feeling which makes a Guy's man certain of a warm welcome in any part of the world where another Guy's man can be found.

It is true that all the Paris students are members of the University of Paris. But that institution is even less tangible, so far as the ordinary student is concerned, than the University of London, and it has no analogy at all with either Oxford or Cambridge. A French student is thus without either a hospital or a university for which he can bear any affection, so that the chief factor which makes the life of an English medical student so pleasant is unknown to him. There is not even anything analogous to the corps which form so important a feature of German university life, and in which the students, if they do nothing else, learn to drink, to fight a duel, and to obey their seniors.

As the students are not members of any special hospital they cannot look to the hospital authorities for any guidance in their work. The university does not supply the place of the dean and the staff of the medical schools of London hospitals in this direction. Each individual must look after himself, and find out for himself what courses to attend and what work to do. The Doyen of the Medical School in Paris is one of the senior professors, and he is generally entirely out of touch with the students. Unless a student has the good fortune to have an elder brother or friend to help him, he is likely to waste much time through want of advice with regard to his work, and he is moreover likely to be led astray by the unhealthy attractions of Paris through want of the clean social atmosphere of an English hospital.

In spite of the absence of *esprit de corps*, it is remarkable what power, the students as a body are at times able to exert. In the beginning of November of last year, two provincial professors were elected to the chairs of Anatomy and Histology in the University of Paris. The students looked upon this as an insult to Paris, so that, at their opening lectures, the professors, together with the Doyen of the Faculty, were received with howls and a shower of eggs and tomatoes. The adjourned inaugural lectures were broken up in the same manner, and the authorities, finding themselves powerless to stop the disturbances in spite of calling in the police, closed the whole medical school until the end of the year, and the Doyen resigned.

There are no separate medical schools for women, the whole of the instruction being for both sexes. At some hospitals there are women *internes* as well as men, and numerous physicians have members of both sexes as *externes*. I was much struck by the large proportion of women students present at a clinical lecture given by Professor Bourget, which I attended in Lausanne, sixteen out of an audience of thirty-four being women. I was told that at some of the Swiss medical schools there are actually more women than men.

The full medical course extends over four school years, each of which lasts for six and a half months. The subjects for study in the first year are chemistry, physics, physiology and anatomy, and in the second year physiology, anatomy, pathology, medicine and surgery. The students are expected to do hospital work during their second, third and fourth years. Practical work in the preliminary subjects and attendance in the wards are compulsory, but attendance at all other courses and at lectures is purely voluntary. Consequently the popular lecturers get enormous audiences, and, as there is nothing to prevent the general public entering, it often happens that many students are unable to find room in the amphitheatre.

A keen man has almost as much opportunity of gaining bedside experience in Paris as in London; he is thus in a much more advantageous position than the students of Germany and the

majority of those of America. A slack man, however, can obtain his qualification after being a *stagiaire* for three periods, each lasting from November 1st to June 15th, without ever becoming either *externe* or *interne*. As *stagiaire* he is attached for eight months to a physician, eight months to a surgeon, four months to an obstetric service, and four months to some other special department. The physicians and surgeons who receive *stagiaires* are the professors of the faculty, and any other members of the hospital staff who are willing to do so for 3,000 francs a year. The *stagiaires* are expected to accompany their chief on his visits, but they do not have to write reports. They are rarely asked questions and, especially in the more popular cliniques, they have very little opportunity of examining the patients themselves.

About a thousand of the medical students in Paris are *externes* of the hospitals. They are appointed, after competitive examination in anatomy and minor surgery, for two years, which are spent in three different services, which may be medical, surgical or special. Their work is similar to that of ward-clerks at Guy's, but in most hospitals very little attention is paid to the writing of reports. They have an opportunity of examining the cases during the visit of their chief and for a short time before his arrival, but as a rule they do not have access to the wards in the afternoon. As the number of *externes* is very high in proportion to the number of patients, even under the most favourable circumstances, a Paris *externe* cannot gain as much clinical experience as an ordinary Guy's student.

The *internes*, about 250 in number, are appointed by examination from externes in their second and third year for a period of four years. They live in the hospital and receive 600 francs in their first year, the pay rising to 1,000 francs in their last year. They are unqualified, but may send in their M.D. thesis during the last two months of their appointment. In spite of this, they fulfil the duties of the English H.P. or H.S., prescribing for the patients in the absence of their chiefs. The surgical *internes*, however, are only rarely allowed to do even the simplest operations, and then only under supervision. Even such minor operations as paracentesis of the chest or abdomen are generally performed by the physician himself, and the numerous physicians who blister and cauterise their patients only rarely leave the treatment to be carried out by their assistants.

The University professors themselves elect their new colleagues from the "agrégé" professors. The latter are chosen after a competitive test consisting of the delivery of an hour's lecture on a set subject after forty-eight hours' preparation, the delivery of a clinical lecture on a patient, and, in the case of surgeons, the performance of an operation on a dead body. Thus the English student, although no doubt he is overburdened by examinations, is fortunate in comparison with the Frenchman who aspires to a professorship, as at every stage—as externe, interne, chef de clinique, médecin des hôpitaux, and professeur agrégé—he has to undergo the ordeal of a competitive examination. There are only four professorships of clinical medicine and one of neurology in the Paris medical school. Hence a distinguished man, whom the authorities wish to honour, is not infrequently elected to a chair for which he is not at all suited. Thus, one of the greatest living neurologists has just been elected professor of morbid anatomy, and was lecturing during the winter on the pathological anatomy of bones and joints.

The clinical professors give one or two clinical lectures a week. They teach in the wards, and often also in out-patients, as in many cases the same men are in charge of both wards and out-patients. In addition to this professional teaching, a considerable number of non-official members of the hospital staffs teach in the wards and out-patients. Their methods are not unlike those of English physicians, with the exception that very few trouble to have proper reports written, and the majority talk the whole time themselves, neither asking questions nor giving any opportunity for discussion.

(To be continued.)

Notices.

University of London.

Rogers Prize, 1908.—Under the will of the late Dr. Nathaniel Rogers, the Senate of the University of London offer a prize of £100, open for competition to all members of the medical profession in the United Kingdom, for the best essay or dissertation setting forth the results of original investigations made by the candidate on any medical pathological subject during the preceding two years.

University Studentship in Physiology.—A University Studentship in Physiology will be awarded to a student qualified to undertake Research in Physiology, and will be tenable in the Physiological Laboratory of the University, or of a School of the University.

For further particulars see the current number of the *London University Gazette* in the Wills Library.

Biennial Year.

To a large number of old Guy's men, the fact that this is "biennial year" adds a distinct zest to life. It means that some time soon they will certainly meet some old friends whom they haven't seen for nearly two years, and, perchance, some that they haven't seen since they were at Guy's as students together. The Guy's Biennial Festival Dinner, as it is called, is without doubt the finest opportunity for old Guy's men to meet together in circumstances peculiarly convenient for chatting over old times. To whatever remote part of the world a Guy's man may go, he has a fair chance of finding a ready-made friend in some other old Guy's man who is there before him. At the biennial dinner he will find some hundreds of old Guy's men, all ready to welcome him as one of themselves, and he would be indeed unfortunate if he did not find amongst them one or more intimate personal friends, students of his own year, fellow-dressers, or clerks to the same chief. It is this feature which has led many old Guy's men to attend with strict regularity every biennial dinner since they were students. Nevertheless, to a considerable section of Guy's men, the "biennial" is still a sealed book. In the busy life of medical practice, they receive every second year a notice of the dinner. But they have never been to one, and to do something one has never done before requires a distinct effort, and so the invitation passes unheeded. Some Guy's men, we have reason to believe, have regarded the biennial dinner as one of those functions, common to some hospitals, where men are persuaded to dine, and, when under the genial influence of social intercourse, are invited to contribute to the funds of the hospital. The Guy's biennial has, of course, no sort of relationship to such festivals. It is strictly a Medical School function, and its sole object the promotion and maintenance of the good fellowship and *esprit de corps* for which this great hospital is so celebrated. Therefore, let all Guy's men note that 1908 is "biennial year."

From the Gazette's Special Pathologist.

C. D. P. S., Huddersfield.—Blood serum inoculated with this swab gave, after incubation, a culture containing micrococci, but no Klebs-Loffler bacilli were found.

H. B., Mitcham. — This sputum contains much greenish-coloured muco-pus. The films show a moderate number of pneumococci and numerous minute faintly-staining gram-negative rods, identical, microscopically, with Pfeiffer's Influenza Bacillus. No tubercle bacilli are detected.

G. E. H., Ramsgate.—There is no pus associated with the abundant blood in this urine, and no tubercle bacilli are present in films prepared from the centrifugalised deposit. There are not to be seen any crystals or distinctive epithelial cells. PATHOLOGIST.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in the Medical Wards.—Messrs. H. I. Janmahomed (Dr. Hale White); A. H. Crook (Dr. Pitt); C. C. Holman (Sir Cooper Perry); W. E. Wallis (Dr. Shaw).

Clinical Assistants in the Surgical Wards.—Messrs. R. G. Oram (Mr. Golding-Bird); K. H. Hole (Mr. Dunn).

Ophthalmic Dressers.—Messrs. H. B. Carter, C. A. Wood (Mr. Eason); F. J. Wheeler, C. G. Sprague (Mr. Ormond, May 1st); W. Johnson, F. J. Kolaporewalla (Mr. Eason); F. R. L. Atkins (Mr. Ormond, June 16th).

Surgeons' Dressers. — Messrs. F. Kahlenberg, L. Bromley, E. L. Elliott (Mr. Golding-Bird); R. C. H. Francis, P. C. Field (Mr. Symonds); V. T. P. Webster, N. A. D. Sharp, H. Steinbach (Mr. Lane); C. H. Crump, J. L. Johnston, A. L. Fitzmaurice (Mr. Dunn).

Obstetric Dressers. — Messrs. H. Chapple, H. W. Heasman, R. P. M. Roberts (Dr. Horrocks); H. C. Lucey, S. J. Darke, T. F. Brown (Mr. Targett, May—June).

Externs.—L. Mandel, C. H. Mills, F. C. V. Thompson, W. T. Clarke, H. L. Duke (May); H. Shahin, A. E. Rayner, H. F. Percival (June); W. H. Watson, A. H. G. Burton, S. J. Darke (July).

Civil.

Page, H. M., F.R.C.S. Eng., has been appointed Honorary Anæsthetist to Guy's Hospital.

Parker, W. Gibson, M.B. Lond., D.P.H. Camb., has been appointed Chief Assistant Medical Inspector of Schools for Somerset.

Shipway, F. E., M.A., M.D. Cantab., has been appointed Honorary Anæsthetist to Guy's Hospital.

Thomas, F. Leslie, M.B., B.S. Lond., M.R.C.S., L.R.C.P., has been elected Honorary Medical Officer to the North Devon Infirmary, Barnstaple.

Military.

Miller, Captain A., M.B. Lond., I.M.S., is promoted to be Major.

Papers by Guy's Men.

A Case of Arrhythmia of the Heart. By J. M. Gill, M.D. Lond.—*The Australasian Medical Gazette* for Feb., 1908.

Perforation of the Œsophagus by a Rabbit-bone: Septic Inflammation of the Mediastinum; Ulceration into the Aorta; Death from Hæmorrhage. By R. Lawford Knaggs, M.C. Cantab., F.R.C.S. Eng.—*The Lancet*, March 28th, 1908.

Some Defects of Speech.

Abstracts from a Paper read before the Physiological Society by Mr. B. R. Parmiter.

Cleft-Palate Speech.—The condition known as cleft palate, when there is gross malformation of the mouth, as one would suppose, interferes very materially with the process of articulation. Even after successful surgical treatment the subject often has a difficulty in speaking, as the artificial conditions cannot be quite the same as the normal, and also because the individual has to grow accustomed to the new state of affairs. However, by careful attention and elocutionary treatment very good results have been obtained.

Lisping.—Lisping is another, though far less serious, defect which may be due to a malformation of the mouth. Either the palate is too high or too narrow, or the frænum of the tongue too short to allow that organ to take up the proper position to form the sound of the letter "s." It may be, however, that a child has never acquired the habit of forming the sound rightly, and has grown up lisping for want of correction. Very frequently it happens that the loss of the front teeth of the temporary set causes a lisp which may persist even after the advent of the permanent ones. This is due to the fact that the habit has been acquired of placing the tip of the tongue between the teeth in much the same position as when the upper incisors were wanting.

Stammering,—We will conclude by a consideration of that very distressing defect known as stammering. This is a condition which has been known for a great number of years. In fact, the first case, I believe, on record is that of Moses, who is said to have possessed a "stammering tongue." Another historical case was that of Demosthenes, the Greek orator, who, we also read, had an impediment in his speech, though of precisely what nature we are not told.

The habit of stammering—for after all it is nothing more nor less than a bad habit—is usually contracted during childhood, as a rule about the fourth year. It is just at this time that there is a general tendency in many individuals towards nervous instability, which may show itself in the form of stammering. The child in whom this is the case is usually taken to the family doctor, who probably pronounces that he will "grow out of it." It is my own unfortunate experience that the chances are that he will grow into it.

The habit may also be easily acquired by imitation, whether conscious or unconscious. For instance, if a boy, for the sake of amusement, imitates the contortions of a stammering school-fellow, that boy runs a great risk of permanently contracting the habit. Or again, if one member of a family stammers others may also begin to do so by association and unconscious imitation of that one. This may be the reason in some instances where it has been supposed to have been hereditary, the defect simply being caused by the association of the child with the stammering parent. However, perhaps it may be considered hereditary, inasmuch as the condition of nervous instability may be considered so, and thus also the tendency for this to manifest itself in the same manner. It is not meant to be implied by this, that stammering is the outcome of what is popularly known as "nervousness," for rather, is it the effect than the cause, although no doubt this tends materially to aggravate the condition. Thus it happens that whereas many stammerers, although comparatively free when speaking to intimate friends or relations, yet by reason of fear of making themselves appear ridiculous before strangers are reduced to almost speechlessness.

Like other conditions of this nature, stammering depends largely on the physical state of the individual. For instance, if the subject is tired or in a low state of health, the defect is far more marked. Again, at times of great excitement or anxiety it will be far more in evidence; for example, if a stammerer engages in a heated argument, or has to make a speech, he is at his worst. In these cases even a non-stammerer may experience a sort of mental stammering. During a discussion a man may become so excited that he does not quite know what he is saying, but tries to say several things at once and ends by uttering nothing articulate. In this case, however, the condition is only temporary, and passes off on the return to the normal state.

In the case of real stammering, although it is apparently the process of articulation which is at fault, yet in reality it is imperfect respiration which is chiefly responsible for the trouble. This is seen in the fact that when out of breath after any exertion the stammerer is found to have very often more freedom of speech than usual. Or again, it is very exceptional to find anyone who stammers during singing—a process during which continued respiration is one of the chief points on which the attention is fixed. From this fact some people have tried intoning every word as a cure. This, of course, gives temporary relief, but it is very doubtful whether any permanent good is obtained thereby, and, to say the least of it, it is very inconvenient to go about everywhere singing.

Now, from what has already been said, it will be understood that one of the chief things for a stammerer to bear in mind is self-control. Any undue excitement or hurry is sure to be fatal. Another thing to be cultivated is concentration of thought; that is to say, that before the person attempts to speak he must have quite made up his mind what he is going to say, as any hesitation is sure to produce a stumbling-block.

For the rest, as has been already stated, the main thing to be rectified is the respiration. It can easily be observed that a stammerer usually holds his breath, at the same time exerting himself to the utmost to articulate some particular letter by sheer force. This is obviously wrong, for as long as he holds his breath he cannot possibly speak. Or at another time he may let all his breath go and try to speak without any. This again is

easily seen to be wrong. The stammerer, therefore, cannot hope to be able to speak freely until he has gained complete mastery over his respiration. This can only be obtained by long and continuous practice of exercises, and so on. If, however, breathing is deficient owing to any obstruction or disease of the respiratory tract, it is essential that this should be remedied before any benefit can be derived from elocutionary treatment. It has generally been found, by those who have made a study of this subject, that the respiration of the stammerer is shallow, his chest measurement below the normal, and his vital capacity low. Thus, the act of inspiration being weaker than normal, it probably acts as a comparatively feeble stimulus for the act of expiration, which consequently may become spasmodic and inco-ordinate with articulation.

Although an absolute cure for stammering is by no means easy to obtain, yet it is far from impossible, and rests largely on the individual himself. There are many institutions in this country that profess to cure stammering by elocutionary methods, and some of these have proved themselves to be very excellent. An account appeared in the *Lancet*, some months ago, of a school in Lancashire for the working-classes which had formed a special class for stammerers. These were treated for an hour or two every day. They were given breathing exercises, and what might be called "vocal gymnastics," by competent teachers. As this has not been instituted long, it is impossible to say how much permanent good is done, but apparently the immediate results are very encouraging. This seems a very good idea and well worth trying in other districts, for stammering is undoubtedly a great drawback to any man, whatever position he may hold in society.

In conclusion, I would advise anyone who is at all interested in this subject to read a little book by Mrs. Emil Behnke, which was lately reviewed in the Guy's Hospital Gazette. It is an excellent work, and in it the authoress treats the subject at far greater length and much more ably than I have done in this paper.

Papers by Guy's Men.

Remarks on the Excision of the Body of the Scapula, with an illustrative case. By R. P. Rowlands, M.S. Lond., F.R.C.S. Eng., with special plate.—*British Medical Journal*, 28th March, 1908.

Myomectomy during Pregnancy. By W. C. Swayne, M.D. Lond.—*The Lancet*, March 28th, 1908.

Lettsomian Lectures on Tuberculosis of the Kidney and Malignant Disease of the Cæcum. By Charters J. Symonds, M.S. Lond., F.R.C.S. Eng. Lectures I. and II.—*Ibid.*, 21st and 28th March, 1908.

Acquired Diverticula of the Sigmoid Flexure considered especially in relation to Secondary Pathological Processes and their Clinical Symptoms. By W. H. Maxwell Telling, M.D., B.S. Lond., M.R.C.P. Lond.—*Ibid.*, 21st and 28th March.

Protection of India from Bubonic Plague. By J. Ashburton Thompson, M.D.—*The Australasian Medical Gazette* for February, 1908.

The Importance of Accurate Diagnosis and the Treatment of Fractures in the Vicinity of Joints. By C. H. Fagge, M.S. Lond., F.R.C.S. Eng.—*The Practitioner* for April, 1908.

Metabolism in a Case of Coma under Rectal Feeding. By P. P. Laidlaw, M.A., M.B., B.C. Camb., and J. H. Ryffel, M.A., M.B., B.C. Camb.—*The Journal of Physiology*, February 28th, 1908.

The Operative Treatment of Cancer of the Large Bowel. By W. Arbuthnot Lane, M.S. Lond., F.R.C.S. Eng.—*Clinical Journal*, April 8th, 1908.

A Report on Fifty Cases of Analgesia by the Intraspinal Injection of Stovaine. By Lawrie H. McGavin, F.R.C.S. Eng.—*The Lancet*, April 11th, 1908.

Hysterectomy Performed upon a Patient with Glycosuria. By John D. Malcolm, M.B., C.M., F.R.C.S. Edin.—*British Medical Journal*, April 11th, 1908.

The Physiological Principles of Physical Training. By M. S. Pembrey, M.A., M.D. Oxon.—*Journal of the Royal Army Medical Corps* for April, 1908.

Lettsomian Lectures on Tuberculosis of the Kidney and Malignant Disease of the Cæcum. By Charters J. Symonds, M.S. Lond., F.R.C.S. Eng. Lecture III. (Illustrated).—*The Lancet*, April 4th, 1908.

Reviews, etc.

The price of books submitted for review should in every case be stated.

The Principles of Treatment of Gout. By Alfred W. Sikes, M.D., D.Sc. Lond. (Ballantyne & Co.)

This little book is an extremely concise and lucid account of the various methods in vogue in the treatment of gout. As a knowledge of the general etiology is a factor of great account in the discussion of the treatment of this disease, it is only natural that a chapter should be devoted to it. This Dr. Sikes has done, and, briefly, he discusses hereditary and the four predisposing factors in acquired gout, to wit, alcohol, over-feeding, deficient exercise, and lead. As regards the first, it is interesting to note that he points out it is not so much the nature of the beverage which has a direct bearing, as the fact that it is excessive libation that is all important; or, in his words, "It is not so much any one alcoholic drink which is to be put down as the cause, but the admixture of different sorts, and, above all, the quantity taken, and its relation to the amount of food consumed, and the habits and constitution of the individual." As to the exact constituent of alcohol which has the deleterious action, he ventures not to say. As to lead, he states that, in this country, it seems to be the most definitely-established predisposing element. Speaking of the direct cause, the excess of urates, he holds that the uric acid is

in a form of combination which the kidneys cannot deal with, and that the excess is due to this. As to what part of the mechanism is primarily at fault, he leans towards the upper portion of the gastro-intestinal tract.

The treatment he divides into general and special, with subdivisions—diet and drugs in the first section, and articular and results of changed metabolism in the second. The question of a non-meat diet he dismisses with the statement that the practical advantages outweigh the theoretical considerations; carbohydrates it is as well to diminish, bearing in mind the disturbed state of the digestive apparatus. The specific action of colchicum, its action being of an anti-toxic nature, he upholds. He has little faith in the so-called uric acid solvents. The alkalis are useful, the potassium salts being preferable. The action is not so much as neutralizers, but in allaying and regulating gastric and hepatic irregularities.

As may be gathered, this monograph contains very little that is new, but is a compact account of all the means at our disposal for the treatment of a disease which, even now, is common enough to merit special attention. The printing and paper are excellent, and it is a book which will repay perusal.

Minor Maladies. By Leonard Williams, M.D., M.R.C.P. (Baillière, Tindall & Cox.) 5s. nett.

This volume is an excellent account of what the author terms minor maladies, and is a highly successful attempt to supply in a short space much of that knowledge which the newly qualified is often lacking in, namely, the treatment of those diseases which in text-books are often dealt with in a cursory manner. The classification and arrangement might have been improved on, but a well-arranged index counteracts this somewhat. The list of formulæ given are those which the author and many of our well-known clinicians have found useful. The section on drugs is well written, though mercury might have been treated in a more up-to-date manner.

For its excellent collection of prescriptions, together with its useful hints on general treatment, this book should find many readers.

Insanity and Allied Neuroses. New Edition. By Dr. Savage, F.R.C.P., and Dr. Edwin Goodall, F.R.C.P. (Cassell & Co., Ltd.) 12s. 6d.

The world-wide popularity of this book has occasioned the publishing of a new edition, the fourth. Dr. Goodall has collaborated with Dr. Savage in bringing this volume into line with the modern trend of the study of mental diseases. A general revision has taken place and special attention paid to pathology. Many new illustrations have been added, and six excellent coloured plates introduced. The classification followed is as in the previous edition, and the section dealing with signing-up, etc., is adequately explicit.

We have no hesitation in recommending this excellent manual to all students, and it is invaluable as an aid to practitioners.

Proceedings of the Royal Society of Medicine. Vol. I., No. 5, March, 1908. (Longmans, Green & Co.) 7s. 6d. net.

The March number of the "Transactions" contains many good things; the clinical cases shown are all of them interesting. Amongst these we notice a case which many will remember being in Esther a short time back. The case was shown by Dr. Herbert French. She was a woman, aged 42, who came to the Hospital to consult Dr. Eason on account of failing vision. Examination revealed a fulness of left upper chest, over left apex. There were vascular disturbances on left side; auscultation revealed an absence of vesicular murmur and voice sounds over the region of the upper two-thirds of the upper lobe of the left lung. Length of history, two years. Inference: a non-malignant tumour displacing or destroying the lung, and pressing on cervical sympathetic nerve behind, and forwards compressing left innominate vein.

An excellent skiagram by Dr. Jordan—and the reproduction in the "Transactions" is truly a work of art—showed a globular mass, distinct from the aorta, in the position diagnosed. There was a very slight eosinophilia; anti-syphilitic remedies had no effect. Suggestions: a hydatid, a lymphoma, a teratoma.

Another striking case was one exhibited by Dr. Arthur Latham. He treated a case of pulmonary tuberculosis by T.R. and fresh horse serum administered by the mouth; the result is very encouraging. The vista opened up by this method of treatment is indeed striking, and Dr. Latham's cases will be followed with great interest.

Amongst other things in the dermatological section is an account of a new substance—a plasticine with a lead oxide base—which had been used to replace the ordinary lead shield in the treatment of pathological conditions of the scalp by means of X-rays.

In the electro-therapeutical section, Dr. Lewis Jones discusses the principles of ionic medication. Dr. Jones is the foremost exponent of this form of therapeutics in England, and his paper was received with the interest it warranted.

Mendelism is ever a fascinating subject, and Mr. R. C. Punnett's paper in the epidermological section gives food for much reflection. It is termed "Mendelism in Relation to Disease," and should give much impetus to the co-relating of mendelian principles to medicine generally.

The laryngological, surgical, medical, obstetrical, and otological sections will be found replete with interesting material, whilst in the odontological section we find a paper on Paraform and its Uses, by J. E. Spiller.

As usual, the high standard of printing and illustrating is maintained throughout.

Ed.—L. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXII., No. 518.] MAY 2, 1908. [SIXPENCE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

May.

Sat. 2. 1st XI. v. Beckenham (Away).
2nd XI. v. Roving Friars (Home).

Mon. 4. Final M.B., B.S.(London) Examination begins
Clinical Lecture by Dr. Horrocks, 1.15 p.m. (Gynæcology).

Wed. 6. 1st XI. v. London County (Home).
2nd XI. v. White House (Away).
Presentation Day, London University.

Thur. 7. Prim. Fellowship Exam. begins.
Messrs. Symonds' and Steward's Take-in commences (Messrs. Stebbing and Henderson).
Practical Exam. for Operative Prize (Dental).

Fri. 8. Final L.D.S. Exam. commences.
1st Professional (L.D.S.) Exam. commences.

Sat. 9. 1st XI. v. Stoics (Home).
2nd XI. v. Mart and Mirror (Away).

Mon. 11. Clinical Lecture by Sir Cooper Perry, 1.15 p.m. (Dermatology).

Tues. 12. Musical Society's Concert, at 8 p.m., in Court Room.

Wed. 13. 1st XI. v. Surrey Club and Ground (Home).
2nd XI. v. Virginia Water (Away).

Thur. 14. Messrs. Lane's and Fagge's Take-in commences (Messrs. Walker and Cook).

Passim.

IN spite of the wretched mood of the Clerk of the Weather of late—and truly he has excelled himself—signs of spring are not wanting in the Park. The spring flowers, after recovering from their first rude shock of having to encounter snow, are making a brave show, some promise of green is apparent in the branches of the noble trees that overtop Clinical, whilst a patient in Addison has assured us that the "singin' of those 'ere bloomin' birds in the mornin' is orful." The Summer Session is a happy one with us, and you men who are returning—we almost said, bronzed—after your month's holiday will, we trust, have many a sunny day at Honor Oak Park which will make amends for the unseasonable weather you have been treated to, and which will temper your work on "stuffy" days in the dissecting room.

THE Ground, so Harris informs us, is in excellent condition. Practice at the nets has already begun, and it is to be hoped that men will show that keenness which is requisite, if we hope to win back the Inter-Hospital Trophy. The trial game is to be held on Monday next, and all men—freshmen, especially—who are desirous of taking part should inscribe their names on the list which is to be found in the smoking room.

MANY a man, we feel sure, who, after strenuous years of labour, has been granted the diploma of the Royal Colleges, must in after years have felt the handicap of being unable to exercise the right, either by courtesy or academically, to the title of doctor. He has passed an examination which, at other centres, entitles him to a degree in medicine, with the undoubted right to the title of M.D. and the consequent right to the designation Dr. That the standard of the Colleges' Final examination is up to that of most other examining bodies no one will be loth to admit. In competitive examinations,

the results show that members of the Colleges hold their own; for the last twenty-seven Service examinations, Conjoint diplomates took first place on eighteen and second on twenty occasions. What could speak more eloquently? In practice the handicap may not be severe, but it is felt in the distribution of many hospital appointments, when a man who has passed an examination, in many cases, less searching than the Final Conjoint, is eligible, whilst the diplomate is not. No less an authority than Professor Osler holds quite strong views in this matter, as may be gathered from a speech at St. Mary's Hospital, wherein he regretted that so many students (in London) passed examinations which were in all respects equal to those passed by provincial students, but nevertheless did not thereby obtain the degree of M.D. Our readers will find an interesting letter on this point in the *British Medical Journal*, April 11th.

We believe a movement is on hand by which this question will be given more prominence. What form it will take we do not know, but probably those in charge will aim at bringing their grievance before the Minister of Education, with a view to the appointment of a Commission. Such a course will undoubtedly be popular amongst students. We would like to know our readers' views on this subject, and will welcome any correspondence.

The alterations in the Eye wards are completed, and great is the improvement. In the wards themselves a considerable re-arrangement of the beds has been made, the former hall in Ruth having been done away with, and a dining hall for both male and female patients having been built at the northern end. The intervening walls between the old entrance lobby, the old Eye Operating Theatre and Sisters' sitting-room have been knocked down. Sisters' sitting-room and bedroom have been moved further towards the main entrance of the medical block. The extra space thus acquired has been utilised in re-organising and re-building the kitchens and lavatories. There is now available an examination room for the use of the Registrars and Ward Clerks, which is fitted up with all the necessary apparatus for testing, and which can be darkened for ophthalmoscopic examinations or operations by artificial light.

The new ophthalmic operating theatre is a thing of joy. The lighting is magnificent, for in addition to a front window, nine feet by eight feet, there is a glass roof, thus assuring that even on a dull day the operator will receive as much light as possible. The operating theatre for the surgeons in charge of the Throat and Ear Departments is equally well fitted, there being no over-head light, however, but the huge window has a westerly aspect. Throughout the whole improvements, the fitments are all of the most modern type, and the department, which for long has wanted attention, can now take its place amongst the most complete in the whole of the Institution.

Some of our readers, no doubt, will remember a volume of Poems, entitled "Devices and Desires," which an old Guy's man, Dr. Habberton Lulham, wrote some years ago, and which met, everywhere, with a favourable reception. In fact, this same volume is now about to enter into a fourth edition, a sufficient guarantee that it has met with the appreciation it deserved. The same gentleman has just published a second volume, entitled "Songs from the Downs and Dunes," and this collection of verse we have received to-day, from Messrs. Kegan & Paul. So far, we have but hurriedly glanced through it, and already it is in the hands of the reviewer; we were immediately struck, however, by the longest poem, entitled "On the Downs." This poem has been fortunate enough to win the special commendation of Mr. Rudyard Kipling, who is accepting the dedication when it appears in the autumn, as a separate book, with a series of pictures of Downland by well-known Sussex artists.

We have not, with the exception, of course, of Keats, numbered many poets amongst Guy's men, and it is generally rather difficult to associate the "misty meridional moon-calf" with the bustling, material sort of dresser or

O. P. O. who keeps a turbulent, ever-swelling crowd of Boro'-ites in the Front within such bounds as satisfy even the exacting demands of Sister, on a Monday morning. We have often wondered to what extent the materialism of his environment at Guy's grated on the sensitive nature of the author of "An Ode to a Nightingale." We find Lord Houghton says: "It soon became apparent that the profession for which young Keats was destined was too unsuitable to be maintained. There remain careful annotations of lectures he attended, but when he had once entered upon the practical part of his business, he found his mind so oppressed with an overwrought apprehension of doing harm, that he determined on abandoning the course of life to which he had devoted a considerable portion of his small fortune." In any case, Keats, although he had served a long apprenticeship, and had such an excellent sponsor as Sir Astley Cooper during his studies in the hospital, abandoned the profession without taking any medical qualification.

We would like to draw our readers' attention to the grand Concert to be given by the Guy's Hospital Musical Society in the Court Room, on Tuesday, 12th inst., at 8 p.m. The programme arranged is a most attractive one, and consists of vocal and orchestral music. Tickets, price 2s. 6d. each, may be obtained from the Matron, Sister Kate, Members of the Committee, and the Hon. Sec., Mr. E. L. Martyn Lobb. It is hoped that the attendance will be a record one, and early application for tickets is advisable.

The Dinner of the Junior Guyite Club is to be held at the Restaurant Frascati (Masonic Room), on May 14th, at 7.30 p.m. Mr. Percy Warner will be in the chair, supported by the vice-chairman, Mr. E. W. Lockhart Stephens. The tickets are 7s. 6d. each, and members are requested to apply to the Hon. Secretary, Dr. J. A. Fraser, Western Lodge, Romford, before May 7th. The dinner promises to be an enjoyable function, and we have no doubt there will be a numerous collection of members who will avail themselves of this opportunity of meeting old friends and colleagues.

We have been asked by a correspondent, which is the oldest students' Institution in the hospital. We find on inquiry that the honour belongs to the Physical Society, which was founded in 1771, and is therefore as old as the Medical Society of London. It was the most flourishing society of its kind in London, being composed of members of both hospitals—St. Thomas's and Guy's—together with the practitioners in the neighbourhood and many medical celebrities from without. Though not essentially a students' society, the present Pupils' Physical Society grew directly out of it when, in 1852, owing to the birth of newer societies in more central parts, its popularity began to wane, and it ceased to exist. The library of the old society passed into the hands of the School. In 1828 a Clinical Report Society was founded; this was before the days when it was obligatory for every student to write reports on cases, and the aim of the Society was to encourage the reporting of interesting cases by the men. So, though now long extinct, this latter Society may perhaps claim priority.

Our heartiest congratulations to Mr. E. L. M. Lobb, who, by carrying off the Murchison Scholarship, has gained a signal honour for himself and his school. This Scholarship, tenable for one year, is of the value of twenty guineas, and was founded in 1880 to perpetuate the memory of Dr. Charles Murchison. Any student is eligible as a candidate who has been registered as a medical student during a period of not less than five and not more than seven years, so that one is not surprised to hear that the number of candidates was considerable. The award is made alternately by the University of Edinburgh and by the Royal College of Physicians, London. A medical qualification is no bar. This year the examination, which took place at the beginning of April, was conducted partly at St. Thomas's and partly at Guy's, and consisted of Papers in Medicine, a *viva voce*, and Clinical cases. Amongst the list of Scholarship holders one finds such well-known names as John Bland Sutton and G. F. Still, whilst it is gratifying to note that in 1906, the last occasion of the award being made in London, it was won by our ex-Medical Registrar, Dr. Bell-Walker.

Two Cases from the Wards.

An Interesting Case from Clinical.

Sidney W., æt. 8, was admitted into John Ward on April 9th for headache, sickness, wasting, and drowsiness.

Family history.—A history of phthisis on father's side.

Previous illnesses.—When three years old he had a "fit," which lasted about half an hour. At the age of five he had a growth removed from the nose, at Shadwell Hospital. At this time he also had a discharge from the right ear, but this cleared up on treatment.

History of present illness.—A month ago a discharge from the right ear was again noticed. Three weeks ago he was sick, and unable to keep down any food. A doctor was called in, and ordered a tonic. For a week after this, there was some improvement, but a fortnight ago he became worse, and complained of headache and drowsiness, with frequent vomiting, and this condition has persisted until admission.

On admission, the pulse was 66, respiration 18, and temperature 96·5°. He has a far-away look, and constantly cries out. When roused he is able to answer questions quickly. There is a large scar on the right side of the head, caused by a fall four years ago. Nothing abnormal in the cardio-vascular, respiratory, or alimentary system. The knee-jerks are present on both sides. Plantar reflex: flexor. No ankle-clonus. Kernig's sign is positive on both sides. No paresis, flaccidity or spasticity of arms or legs. Ptosis is well marked on the right side. The right internal rectus is paralysed. The right pupil is larger than the left, but reacts to light. Optic neuritis is well marked in both eyes. The child complains of great pain in the head, but seems to localize it more to the right side. No swelling or pain in the mastoid region.

Operation.—Mr. Fagge explored the antrum on the right side, and found a cholesteatoma. The lateral sinus was exposed, and found to be healthy. The opening was then enlarged by chipping the bone away all round, and the dura mater exposed. This membrane was red and granular. On incising it, a quantity (about two ounces) of very foul pus escaped. A large drainage tube was inserted and the wound packed round with gauze.

(A bacteriological examination of the pus showed the presence of Friedlander's bacillus).

The paralysis of the right internal rectus cleared up in thirty-six hours, and the ptosis was scarcely perceptible three days after. Optic neuritis was still marked.

On April 11th, the lad was free from pain, except when the wound was being dressed.

P. S. P.

Case for Diagnosis.

Stephen 19, under Dr. Pitt. M. M., æt. 25, farm labourer, single. Admitted for swelling in left side of abdomen, March 21st, 1908.

Family history unimportant.

History of present disease—

Nov. 27th, 1907.—Patient had abdominal pain and swelling. Temperature 102°. Diarrhœa of five days' duration. Typhoid was suspected.

Nov. 28th.—Enlargement of liver. Dullness in both flanks up to two inches of umbilicus, altering in position. *Urine.*—Faint trace of albumin, ʒxv. in twenty-four hours. No blood, casts, pus or bile present. Diarrhœa still present. Temperature 103°. Widal's reaction gave negative result. Diarrhœa continued for a week. Ascites still present. Temperature between 101° and 103°.

For a month after this he had evening rise of temperature, 100° to 102°. At the end of this time fluid began to lessen, and temperature dropped to normal. The dullness in left flank continued, not altered by change in patient's position, whilst an ill-defined sense of something resistant was present.

During the last month, February, he has steadily improved in health. Appetite good. Urine 40–50 ounces daily; no albumen. Quite capable of walking about daily.

No history of tubercle in family. No specific history. Had been drinking heavily previous to his attack in November.

Condition on re-admission.—Temperature 96°. Pulse 132. Respiration 28. Patient looks well nourished and has a good appetite, and is in no pain. Nothing of interest in nervous, respiratory or circulatory systems.

Leucocyte count 10,000. Calmette's reaction ½ per cent. positive.

Alimentary system.—Tongue pale, not furred. Teeth good. Abdomen is fuller than normal, but the umbilicus is not stretched transversely. Moves poorly and very resistant to palpation. No marked area of cutaneous hyperæsthesia or anæsthesia. No movable dullness, no thrill.

Palpation.—Hard, ill-defined, apparently deep-seated mass can be felt to left of abdomen. Irregular surface, not markedly so, is moderately fixed, movable to the extent of one inch. No movement on respiration. In the left iliac region a definite edge can be felt, tender on pressure, and can be traced upwards to costal margin. The mass extends to right of mid-line for about two inches, but has no defined border, except where above mentioned. No notch to be felt. Space can be felt between ensiform cartilage and tumour.

Percussion.—Impaired note over lower one-third of tumour, and a subtympanitic over upper one-third.

Rectal examination revealed a hard, irregular indurated mass in left wall of pelvis and at posterior aspect of base of bladder. No glands in groin or behind sterno mastoid.

April 11th.—No appreciable change in patient's condition.

S. McK. S.

ROYAL COLLEGE OF SURGEONS OF ENGLAND, APRIL, 1908.—Member of twenty years' standing elected to the Fellowship: Mr. H. Pottinger Keatinge, Director of the Egyptian Medical School at Cairo.

Guy's Hospital Past & Present Nurses' League.

On Friday last, April 24th, the Eighth Annual General Meeting of the Guy's Hospital Past and Present Nurses' League was held in the Nurses' Home. Tea and coffee were served previous to the meeting, at which there was a great gathering of past members, some of whom had not seen each other for some years.

Soon after eight o'clock all adjourned to the large Recreation Room where the business of the evening was gone into.

Miss E. M. Fox, the Matron of Tottenham Hospital, was asked to take the chair, and the minutes of the last meeting were read, confirmed and signed.

The Matron gave a short report of the last year's work. About 60 members had been added to the League, 160 nurses had spent "week-ends" and "nights off" at the Cottage, and 1,189 had been down for short visits to tea, etc.: 2,720 volumes had been taken out of the Nurses' Library, and the Musical Society had given a most successful concert in December. The Swimming Club had held swimming competitions, and the Tennis Club a tournament. The bicycles had been used more than during the previous year. The Debating Society had given a debate, and the Photographic Society had started a portfolio to circulate among members.

The result of the ballot for Members of the Council for the ensuing year was next made known.

Debating Society.—Sister Lydia, Nurse Shackleton.

Cycling Club.—Sister Naaman, Nurse Wakeling.

Tennis Club.—Sister Mary, Nurse I. Du Sautoy.

Nurses' Library.—Sister Cornelius, Nurse Farrow.

Choral Society.—Sister Kate, Nurse A. Ward.

Swimming Club.—Sister Ethel, Nurse Bodenham.

Photographic Society.—Sister Eleanor, Nurse A. Lloyd.

Orchestral Society.—Sister Surgery, Nurse Bingham.

Miss Fox said that it gave her great pleasure to be there that evening, and she was very glad to hear that the League was in such a satisfactory condition. She had noticed in the report given by the Matron that the Debating Society had only held one debate; she thought that this Society should be better supported. People were always afraid of hearing their own voices, but it was a good thing to be able to give one's own opinions on the topics of the day. Subjects there were in plenty, and Nurses should be able to state their own opinions, and hear others. She wished the Society every possible success during the coming year, and hoped that the present members would support the different sections, and make them a great success, and in this way widen their interests. One of the first ideas of the League was good fellowship. Hospital friendships, she thought, were ideal friendships; there were none like them; they were not like the bosom friends of our schooldays, for we are older, and are able to choose our friends with better judgment. Her own experience was, that hospital friends always stuck to each other (hear, hear); they had so many things in common, and were bound together by the bond of good fellowship, good will, and good work, which was a three-fold bond not easily broken.

A short discussion was next raised as to the subjects for post-graduate lectures, to be given during the year, and several suggestions were received from those present.

The Matron, in the absence of Mrs. Fagge, the Hon. Treasurer, said that the Balance Sheet for the year was very satisfactory. A sum of £250 had been paid off the capital account, and there remained a balance in hand of over £44. This was extremely gratifying, for when she first became the Hon. Secretary of the Nurses' League, or the Recreation Society, as it was then known, they were very much in debt, and, as many of them knew, debt was a thing she abhorred. Mrs. Fagge, the Hon. Treasurer, had been indefatigable in her efforts to get hon. members and to reduce the debt, and although she was not able to be with them that evening, she had been present at the Council Meeting during the afternoon, and was still willing to act as the Hon. Treasurer. She was sure everyone present would accord Mrs. Fagge a most hearty vote of thanks for all the trouble she had taken on their behalf. The vote of thanks was carried in the usual way, amid much applause.

Miss Hyland, the Matron of the Royal Devonshire Hospital, Buxton, next said that she had very great pleasure in proposing a very hearty vote of thanks to the Matron, the Hon. Secretary, for all the trouble she had taken on behalf of her present and past Nurses. She knew quite well the Matron's dislike to debt of any kind, and she hoped that very soon they would hear that the debt on the League was wiped out altogether. (Much applause.)

The Matron, in reply, thanked the members for the kind way in which they had responded to the vote of thanks, and she would very much like that a similar vote should be accorded to the President of the League, Mrs. Cosmo Bonsor, and the Associate Members of Council, These ladies had been of great assistance to Mrs. Fagge in making the work of the League known outside the hospital, and the Countess of Bective and Mrs. Hale White especially, had taken a great interest in the working of the League during the past year. The vote of thanks was then carried with much applause.

A vote of thanks was accorded to Miss Smith, on the proposal of Miss Haughton, Matron of Sir Patrick Dun's Hospital, Dublin, and also to the retiring members of council, and the business of the evening was brought to a close by a hearty vote of thanks being proposed by Miss Laurence, Matron of the Chelsea Hospital for Women, to Miss Fox for so kindly presiding at the meeting that evening. Miss Fox was very busy in her work at Tottenham, and she (the speaker) quite agreed with what had been said about everyone being able to express her own opinion. She herself could testify that Miss Fox gave her nurses very good facilities for expressing their own opinions. Miss Fox, in reply, thanked Miss Laurence for the kind way in which she had spoken of her hospital at Tottenham, and said that she tried to train her nurses on the same lines as those at Guy's,

for she considered Guy's Hospital was the best training school in the world. (Great applause.)

After the meeting some prize slides kindly lent by the Royal Photographic Society were put through the lantern, together with several hospital scenes, such as the Park on Prize Day, hospital tea and coffee parties in the Nurses' Home, taken by flashlight. Much amusement was caused by one slide in which a Guy's Sister was shown trying hard to overcome the difficulties of a massage class, etc.

Guy's Hospital Nurses' Photographic Society.

THE Fourth Annual Exhibition of the Guy's Hospital Nurses' Photographic Society was opened in the Nurses' Home on Friday, April 24th. Mr. F. T. Hollyer, F.R.P.S., kindly acted as judge.

The entries, numbering 133, were arranged on screens covered with suitable material, and artistically draped with green art muslin by Sister Eleanor. This was a great improvement on the arrangements of former years, and proved an excellent background for the photographs. The exhibits were divided into four classes, and the judge's awards were as follows:—

CLASS A.—Landscape, Seascape, and River Scenery.—1st prize, On the River Meon, Nurse Stones; 2nd prize, Birch and Bracken, Miss M. Smith; 3rd prize, Crackington Haven, Nurse A. Lloyd.

CLASS B.—Portraiture, Figure, Animal and Flower Studies.—1st prize, Lambs in the Orchard, Miss Grahame; 2nd prize, The Fishers, Miss Oxford.

CLASS C.—Architecture and Interiors.—1st prize, The Nurses' Home, Autumn, Miss M. Smith; 2nd prize, At Villeneuvi, Miss Oxford.

The Special Prize for the best picture in the Exhibition was awarded to Miss Smith for the photograph of the Nurses' Home in Class C.

After he had judged the photographs, Mr. Hollyer made some complimentary remarks on the efforts of the past year, and gave some valuable hints and suggestions for future work. The prizes were kindly placed at the disposal of the judge by the Countess of Bective, Lady Henry Bentinck, Mrs. Cosmo Bonsor, and Mrs. Trevelyan Martin.

Dental News.

OUR late House-Surgeon, Mr. Gibbings, has sailed for South Africa, where he intends to practise; he carries with him our best wishes for his success in his new sphere.

Mr. Hochapfel, writing from Blomfontein, wishes the men up for the final this week the best of luck. Mr. Hochapfel is enjoying the sunny climate of South Africa, and does not long for the fog and snow of London.

The large mechanical laboratory has been refloored with boards—a great improvement on the old blocks, which seemed to be of a wandering disposition, for one rarely found them in their normal positions.

CASES.

The case of fractured mandible (A. B., æt. 6), recently reported in the GAZETTE, is doing very well. Union between the two halves of the jaw has taken place; the splint—a Gunning—is still kept on. The child is fed with fluids through a tube, and is in excellent health. It is now four weeks since the accident.

An interesting case of palatal abscess was recently seen. The patient, a small girl, æt. 7, presented herself at Out-patients with a large fluctuating swelling on the left half of the palate. The left upper lateral was loose, but not carious; the second upper temporary molar on this side was carious. Both teeth were removed, and the pus drained through the palatine root of the upper temporary molar. Next morning patient came up again with a swelling in the same position. Apparently the pus again collected, because the dependent position of the abscess sac did not allow of free drainage. An anæsthetic was administered, and the abscess sac freely opened into the mouth and scraped. Healing quickly occurred.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Fees in the I.M.S

DEAR MR. EDITOR,—I do not think that the letter of "One Who Knows," published in your issue of March 7th, gives quite a fair view of the position. I have a copy of the latest Government Circular before me as I write, and it is laid down that if the fees charged are over £1 1s. a visit, or in certain cases over £2 2s. (and even when they are not, if the total is over £10 in one month), a confidential application has to be made through the Inspector General of Civil Hospitals to the Director General I.M.S., but the former, "*before forwarding the case to the Director General Indian Medical Service, the Inspector General of Civil Hospitals will consult the Local Government (without disclosing professional details) regarding the propriety of the fee claimed, and will communicate the views of the Local Government to the Director General, Indian Medical Service, in forwarding the case.*"

Now, Sir, I do not see that the Local Government—a lay body—however intelligent it may be, has any rightful claim to be able to judge the correct ratio between the treatment administered and the fee charged.

From what I have seen and heard out here, I feel sure that the Native—gentleman or otherwise—is perfectly well able to look after himself as regards fees, and there is a shrewd suspicion, I think, out here that these regulations originate from lay jealousy of our right to private practice rather than to any sentimental desire to protect the simple (?) Native gentleman of high position! I hope the Government of India will see fit to speedily cancel "in toto" these obnoxious regulations.—I am, Sir,

"ONE WITH SUSPICIONS."

Spinal Analgesia as a Routine Method in Surgical Practice.

By LAWRIE MCGAVIN, F.R.C.S. Eng., Surgeon to the Seamen's Hospital, and Lecturer in Clinical Surgery in the London School of Clinical Medicine.

ALTHOUGH the subject of Spinal Analgesia, which, in this country at least, is still of comparatively recent introduction, has begun to give rise to much useful discussion, it is still almost a sealed book in most of the larger hospitals of London; and, even in those in which it has been tried for any length of time, its use is so far limited to the practice of, at most, one or two members of the surgical staffs of such hospitals.

It struck me, therefore, that the experience of nearly a year's work might prove of service, or at least of interest, to Guy's men, both past and present. The following remarks convey, as briefly as space will permit, the impressions I have formed of spinal analgesia from a personal experience of over one hundred cases done in my wards in the Seamen's Hospital. I have not gone into the details of individual cases, since half of them are already in the Press, and also from considerations of space. I have, in this paper, simply given such information as I can for the purpose of assisting those who have not yet given the method their consideration, or who are anxious to acquaint themselves with its practical application.

In the first place, it must be understood that spinal analgesia is *not* intended to supplant general anæsthesia completely; that it in no way threatens the position or livelihood of the anæsthetist; and that, like everything else, it has its disadvantages; and yet, in spite of these, there is little doubt that it is to become the anæsthesia of the future. And indeed, those who have never seen spinal analgesia employed can have little knowledge of the simplicity, the comfort to the patient, and the freedom from anxiety for the surgeon which its use guarantees.

Since the introduction of stovaine by Fournier, not only has this drug, but many others, such as tropacocaine, novocaine, alypin, etc., been used for the production of analgesia by injection into the theca vertebralis. My experience is concerned with stovaine only, and of the preparation of it used by Barker, and originally prepared for him by M. Billon, of Paris. This preparation, now manufactured by Poulleno Frères, is sent out in sterilettes, each of which contains 2 cc. of the solution. Each of these cubic centimetres contains ·05 gm. of stovaine and ·05 gm. of glucose, the object of the latter drug being solely to render the solution of a rather higher sp. gr. than the cerebro-spinal fluid. The injection syringe devised by Barker is, I think, the best. It is provided with a canula which is about one millimetre longer than the needle through which it passes, in order that when the needle has entered the theca, and cerebro-spinal fluid appears, the solution may be injected accurately into the theca without the danger of wounding the nerves of the cauda equina by introducing the needle any further. The needle is provided with a stylet, and the points of both are equally bevelled, a pin fitting into a slot at the proximal end ensuring that the bevelled surfaces shall lie in the same plane.

The barrel of the syringe is divided into two primary divisions, each representing a capacity of 1 cc., and each of these is again divided into five secondary spaces. Now, as each cc. in the sterilette contains ·05 gm. of stovaine and the same amount of glucose, each of the secondary divisions on the syringe will represent ·01 gm. (one centigramme) of each of these drugs.

Stovaine, which is hydrochlorate of dimethylaminobenzoyl-dimethylethylcarbinol, is a synthetic product which is freely soluble in water, which it renders acid to litmus. It is incompatible with mercuric salts, and is destroyed by the least trace of alkalis. It is equal to cocaine in its analgesic properties, and much less toxic in its action.

During the year past I have employed it as a routine method at the Seamen's Hospital, and the following remarks are the result of such experience as I have gained from its use in more than one hundred cases.

Limitation of application.—It may be said that, below the umbilicus, all operations may be carried out under spinal analgesia without exception. The effect of the drug is most prolonged and most profound in the area supplied by the sacral plexus; consequently it is especially useful in all operations on the bladder, urethra, and rectum; excision of the rectum and total prostatectomy being readily accomplished under its influence Appendicectomy, colotomy, and pelvic operations in women are similarly easily dealt with. Above the umbilicus the analgesia is of shorter duration, since it passes off in the reverse direction to that in which it was established, and, therefore, although

many operations may be commenced at this level, it may be necessary to repeat the dose of stovaine, or finish the operation under general anæsthesia. I have, however, quite recently been able to remove, by hysterectomy, a uterine fibroid, weighing eight pounds, which rose in the abdomen to the tip of the ensiform cartilage, by the aid of one injection of stovaine (7 cg.), which provided an analgesia of nearly an hour and a half.

Special indications for the use of stovaine.—These are chiefly seen in cases complicated by cardiac and pulmonary disease. Thus, double aortic disease, mitral incompetence, aortic aneurysm, asthma, and chronic bronchitis, especially when associated with plethora; intestinal obstruction when fæcal vomiting has been present for some hours, and shock resulting from trauma or an abdominal catastrophe, are all conditions calling for the use of spinal analgesia, rather than general anæsthesia, when an operation is to be undertaken. The cleansing of a burned area of large extent may be accomplished without any increase of shock. The insurmountable apprehension entertained by many nervous women for the loss of consciousness entailed by the use of a general anæsthetic, and which is often a real danger, especially in the case of chloroform, is easily overcome by this method.

I am forcibly reminded of the occasional danger of chloroform in certain unsuspected cases of cardiac disease by a case of my own, in which death took place on the operating table during a minor operation on the rectum. The patient was found, post-mortem, to have suffered from syphilitic fibrosis of the heart. This case, done before I commenced to employ spinal analgesia, would probably have been alive to-day had this method been used.

The age limits for the employment of spinal analgesia are, I believe, still uncertain, and in my own practice I have not yet used it in any patient younger than fourteen or older than seventy, but cases have been reported as early as five and as late as eighty-five years. I can see no valid reason why stovaine should not be used in young children, provided the dose is graduated to the age, or, perhaps better, to the body-weight of the patient, but, as yet, I am not in a position to express an opinion on this point. The chief difficulty in such administrations would seem to me to be that of ensuring the immobility of the patient during the introduction of the needle. In two cases I administered 4 cg. of stovaine to boys of fourteen and sixteen years of age; the result was satisfactory at the operation, and no ill-result followed.

It has been said that septic conditions are a contraindication, but I have not found this borne out in practice; there seems to me to be no difference whatever in the reaction to the drug in septic and aseptic cases.

Preparation of the patient, etc.—It must be distinctly understood that the introduction of an instrument or a solution into the theca vertebralis constitutes a surgical operation, bearing with it responsibility and some danger, and although with proper precautions this danger can be reduced almost to vanishing point, no pains must be spared to attain this vanishing point. In my own wards, the skin of the patient's back is prepared for injection in identically the same manner as if such an operation as laminectomy was about to be performed. It is rendered as aseptic as possible the night before, compressed all night, the compress is changed in the early morning, and the part is again cleansed before operation. The risk of sepsis, which has been much insisted upon, is, I believe, very remote when the needles and syringe are thoroughly prepared. The former should be treated with ether, to remove any grease, and should then be thoroughly boiled in *distilled water*, since the least trace of soda, or any other alkali, will at once destroy the stovaine. The lumen of the canula and needles should then be seen to be perfectly clear by forcibly syringing, and the stylets are passed into the needles and seen to fit accurately.

Although it is unnecessary to starve the patient as before a general anæsthetic, it is wise, where the operation is a high one, and where it is likely to be prolonged, to make the last meal as light as possible and at least two hours before injection, since it may happen that a little chloroform may be needed towards the end of the operation; this, however, is quite unusual. The bowels should be cleared thoroughly: stovaine produces so complete a relaxation of the sphincters, that an accident may happen if this is not carefully attended to.

Position of the patient.—This is largely a matter of choice; the points to be aimed at are the rendering prominent of the spinous processes, their exact alignment, and their wide separation from each other. The patient may be placed either on his side, with the knees drawn well up and the head and shoulders bent well down; or he may sit up, on the edge of the table, the legs hanging down, and with the back arched convexly towards the operator. This

latter position has the advantage especially of ensuring the column being vertical, and of bringing greater pressure upon the cerebro-spinal fluid and consequently of rendering the dura more tense and easily punctured. In my earlier cases I used the first position, as I thought that the less the patient was moved after injection the better; I have, however, lately adopted the second, and I think with better results both as to duration and height of the analgesia.

The patient then, being in position, and the site of injection cleansed with turpentine, ether soap, ether, and finally with a solution of biniodide of mercury in spirit, and thoroughly dried with a sterile swab, the part is covered with a sterilised towel.

Dosage.—A sterilette is cleansed by washing it in biniodide solution and then in sterilized water, and the point is broken off near the bulb; the point of the canula, mounted on the syringe, is passed into it and the contents are withdrawn; any air bells in the syringe are expelled by tapping the sides and pushing up the piston.

The question of dosage must now be settled. My first case, one of very large inguinal hernia, in which it was necessary to implant a double filigree of silver wire, was given 6 cg., and this resulted in an analgesia lasting eighty-five minutes. I later reduced the dose to 5 cg. for hernial operations of the ordinary type and found it sufficient for most of these; there is, however, no doubt that many patients are more insusceptible to the drug than others, and I have now adopted 7 cg. as the standard dose for all except perineal cases, in which I have fonnd 4 cg. or 5 cg. to be sufficient. In several cases in which, with 6 cg. or 7 cg., analgesia of sufficient height or duration was not obtained, I have administered a second injection at the end of ten or twelve minutes, of 4 cg. or 5 cg. This has always produced the required result, and no harmful effects have been seen. On one occasion, however, in which 8 cg. were used in a *single dose*, although no actual trouble resulted, the analgesia was unnecessarily high (viz. to the clavicles), and the patient complained of "air hunger": the respirations were, however, full of normal rhythm, and there was no cyanosis. Six centigrammes ought to serve in most cases, but the necessity for a second injection will, as a rule, be avoided if 7 cg. be given at first, and I have no doubt that this is a perfectly safe dose for an adult. The syringe, then, is emptied till the fluid stands at the seventh division from the needle and is then laid aside.

The injection.—The usual site chosen for this is the second or third lumbar interspace. The spinal cord ending at the second lumbar vertebra, the cords of the cauda equina pass off on either side, leaving a diamond-shaped space opposite the interspaces mentioned, into which the injection may be made. The second lumbar spine is on a level with the highest point of the iliac crest, and this point must therefore be sought, and from it the spine determined. This being done, the left forefinger is placed upon the third lumbar spine, the needle with its stylet being held like a pen in the right hand. A little ethyl chloride is sprayed upon the part, which must not be frozen hard, as the needle point must on no account be turned. The ulnar side of the hand being placed against the patient's back for support, the point of the needle is entered just above the left forefinger, midway between the spines, and is pushed directly inwards and slightly upwards for about an inch, *directly in the middle of the back*. The stylet is now withdrawn and the needle is pushed steadily onwards till the appearance of fluid proves the arrival of the needle point in the theca. The flow varies greatly from single drops at distinct intervals, to a gentle and continuous stream. Occasionally it is suddenly interrupted as if by the floating up against the needle point of one of the nerves of the cauda equina. If the needle is rotated gently, the flow will at once recommence. A small quantity of fluid is allowed to escape (usually 5 cc. to 10 cc., the accurate measurement is neither easy nor important), and the canula, mounted upon the syringe, is passed into the needle, which must be firmly held in position meanwhile; the contents of the syringe being injected into the theca, the canula and the needle are withdrawn together.

Failure to pass the needle into the theca may be due to three causes, viz.:—

a. Inaccurate alignment, the needle passing to either side of the theca.

b. A blunt point pushing the theca before it without perforating.

c. Close apposition of the spines due to pathological causes.

That one may succeed in entering the theca, but fail in drawing off fluid, is, I think, certain; it can only be explained, I fancy, by some fold of the arachnoid membrane, or some nerve of the cauda, being carried against the point of the needle. Some help as to the alignment in stout patients may be gained by the fact that pain is at times complained of in the leg of the side to which the needle is directed, the cauda being touched on that side. The needle point may be turned not only by frozen skin, but by impinging against the vertebral body

beyond the unopened theca, or upon the under-surface of the spinous process above, or the upper surface of that below. Again, I have met with cases in which, although fluid comes freely from the theca, the strongest pressure of the piston fails to make the solution enter the canal. I have been quite unable to account for this; it is not due to the piston jamming. In such cases I have been compelled to reintroduce the needle in the space below, and have then found no difficulty. It is wise to keep accurately in the middle line lest the meningo-rachidian or the intradural vessels be wounded. I have seen slight hæmorrhage from the canula on several occasions, but in none has any trouble arisen.

The depth of the theca from the skin will, of course, vary with the individual patient; it is usally found at a depth of $1\frac{3}{4}$ to $2\frac{1}{2}$ inches.

It is not necessary to place any form of dressing upon the puncture, nor is it, I think, advisable, at least, not at the actual time of injection. The puncture hole closes at once by its own elasticity, and any delay in placing the patient in position for operation is liable to interfere with the development of analgesia. A sterile towel is simply placed under the back.

Position after injection.—As soon as the injection is made, the patient is turned upon his back, and his sacrum is raised upon a bandaging rest (four or five inches in height), and the head and neck being raised to an equal degree, the lowest point of the theca will be at the level of the fifth or sixth dorsal spine. The higher specific gravity of the solution, due to the presence of the glucose, causes it to sink gradually to this point, mixing at the same time with the cerebro-spinal fluid, with the result that the nerves from this point to the cauda equina are rendered incapable of transmitting sensory and, to a great extent, motor impulses. The effect will, of course, be more marked at the point of greatest concentration of the solution, *i.e.*, the level of injection; consequently, as already stated, the earliest and most prolonged analgesia will be found in the perineal area, the penis, and the scrotum.

At almost the same moment (occasionally even earlier), the knee jerks and plantar reflexes disappear, the former before the latter. Then the legs, although they can still be raised, are complained of as being numb and heavy. Soon, usually in about three or four minutes, they can no longer be raised, and the analgesia becomes complete in the feet, legs, thighs, and groins, from below upwards. Sensations of heat and cold are interpreted as those of touch simply. The actual height of the analgesia does not appear to depend entirely upon the dosage, or upon the period of elevation of the sacrum, since, if the rest be removed before the analgesia has reached the groins, it will still, at times, rise to the nipples, or higher, and this even with a comparatively small dose. The upper limit of analgesia is often very sharply marked out, an area of half an inch in width leading from complete sensibility to complete analgesia.

In cases where the analgesia appears to lag in its rise, it may often be induced to progress by making the patient take one or more deep inspirations, thus probably setting up an upward current of cerebro-spinal fluid in the theca by emptying its venous plexuses.

The rest may be removed when the analgesia reaches the groins, if the rise has been fairly rapid, but the head is still kept slightly elevated, in order to prevent any encroachment on the cervical enlargement of the cord. The patient is now in a fit state for operation, and the proceedings are hidden from his view by means of a sheet hung across the chest and fixed to a screen on either side of the table. Finally, the sterilised towels are arranged, one of these covering the side of the sheet next the operator.

Condition on the table.—In many of my cases no phenomenon of any kind was noted from first to last, the patients declaring themselves perfectly comfortable. In others, the most frequently met with were, perhaps, pallor, nausea, and feebleness of pulse, all of which symptoms were of very slight degree, lasting seldom more than a few minutes. In one case, vomiting occurred without any other symptom, and in another, well-marked unilateral sweating of the head and neck was seen. Respiratory symptoms were only subjective in one case,* that already mentioned, in which there was "air hunger." In many there was noticed a tendency to draw a long sighing respiration at long intervals, between which the respiratory rhythm was normal. This appears to have been quite unnoticed by the patients themselves, as they all declared themselves well on being asked if they felt ill or in pain. In three or four cases, rigors were met with without pyrexia; one or two complained of feeling cold. These rigors never lasted more than a few minutes, and were not followed by exhaustion, sweating, or increase in the pulse rate. In no case was paresis of the sixth pair of nerves, mentioned by some writers, seen. Many patients smoked or chatted during their operations, and all, with one exception, declared

* Since going to press, I have noted this phenomenon in two more cases; and in one, paresis of the intercosto-humeral nerve was present: no ill-result followed.

themselves pleased with the method; and, again, with one exception, all who had had a general anæsthetic previously, said they much preferred spinal analgesia. Half-a-dozen or more, requiring a second operation, of their own free will chose the latter method.

The complete relaxation of muscle produced by stovaine was a very notable feature; the abdominal muscles became markedly flaccid, and the sphincter ani patulous; straining during operation was thus completely absent. In a case of strangulated hernia, where the bowel was very tightly constricted, and the sac contained a very large mass of it, spontaneous reduction took place as soon as the analgesia reached the umbilicus.

Points in regard to the analgesia.—The analgesia varied much in apparently similar cases, in time of establishment, height, and duration. The shortest time in which any operation could be commenced was four minutes (an external urethrotomy), and the longest time of establishment from a single injection was twelve minutes (a case of inguinal hernia).

The height to which the analgesia rose was usually the level of the umbilicus or a little above it; in several it rose to the ensiform cartilage: three or four cases became analgesic to the second rib, one of them having well-marked analgesia along the inner side of both arms (intercosto-humeral): and in three cases the whole body up to the root of the neck was rendered analgesic. In spite of this very high analgesia, there were no alarming symptoms, and respiration appeared to be quite unaffected. This undoubtedly gives reason to hope that the circulatory and respiratory nerves may in time be proven to be more insusceptible to the drug than the rest of the nervous system, as they are to general anæsthetics.

In duration, much variation was seen, even in cases of similar physique, receiving similar doses. The average was forty-five to fifty minutes after doses of 5 cg. and 6 cg., while with a dose of 6 cg. to 7 cg., analgesia of from forty to ninety minutes was the rule, taking the groin as the test level.

The most constant factor in spinal analgesia is its depth: once it has attained the desired level it is complete and absolute. There is no response, either muscular, respiratory, cardiac, or pupillary (such as is often noted in general anæsthesia when the patient, although anæsthetised, is not *fully under*), even to the severest stimuli. The analgesia is as deep in bone as in skin; and amputations, osteotomies, and drillings, are quite unfelt.

Ample warning is given of the approaching return to sensation, the upper limit of analgesia gradually sinking lower as time passes. This is easily tested by the touch of a needle point, and if the operation is far from being completed, it is a simple matter to give another injection. The great nerve trunks themselves share equally in the analgesia, and I have on one occasion completely dissected the internal and external popliteal nerves from off the sac of an aneurysm, drawing them forcibly to one side or other, without altering the cardiac or respiratory rhythm by a single beat or respiration. As regards the peritoneum, the depth of analgesia is not always quite so constant. In a few cases, although the rest of the operation has been quite unfelt, complaint was made of discomfort and nausea on forcible dragging on the mesentery, omentum, or stomach, etc. It would appear that the analgesia does not rise to quite such a height in the abdomen as in its walls: in some cases, however, it undoubtedly does so; since, although in one case I failed to complete a gastro-enterostomy with an analgesia reaching the nipples, I was able in others to remove the appendix and complete a ventrofixation of the uterus with an analgesia just reaching the umbilicus. The question of how far the sympathetic nerves are affected by stovaine is still, I think, *sub judice*.

Dean, in a recent paper, is of opinion that spinal analgesia minimises the probability of tympanites; but in two or three of my cases tympanites seemed to be present rather markedly; this may have been accidental, but it suggested itself to me at the time as being an indication of intestinal paresis due to the action of the drug through *rami communicantes*.

Return of sensation.—As the effect of the stovaine commences to wear off, the level of the analgesia, as stated, gradually sinks. At first, the process is a comparatively slow one, but as the upper part of the thighs is reached, it progresses more rapidly, and is accompanied by the sensation of "needles and pins," and by a feeling of weight in the limbs. The perinæum, being the part earliest affected, is usually the last to clear up, after which the reflexes gradually return. The whole process occupies a period usually of three-quarters of an hour to an hour. In no case has any undue prolongation of the analgesia or paresis been seen; indeed, the difficulty, if there is any, seems to be not how to get sensibility to return, but how to secure a long period of analgesia.

After-effects.—The after-effects of spinal analgesia seem to have been greatly exaggerated by

many writers. I have heard rumours of many curious sequelæ, from different quarters, as the result of using stovaine, such as permanent paraplegia, spinal meningitis, paralysis of respiration, and other terrors. I am bound to say I know of no authenticated case in this country, and I prefer to accept, with the greatest reserve, reports from Continental sources which are lacking in some of the most essential details. Many different solutions of the drug are used abroad, some of them containing adrenalin and other ingredients, which probably account for such phenomena, if, indeed, they have been seen. I cannot help feeling, in view of my own experience, and of the much greater experience of Mr. Barker, that stovaine, as used by him and in the doses mentioned, is a comparatively harmless drug, and that, with ordinary care, it is free from the dangers of chloroform.

The after-effects that have been met with in my own wards have been, in order of frequency:—

Headache, on one or two occasions severe, generally mild, and always yielding to aspirin in 10 to 15 grain doses.

Backache, and sometimes pain in the extremities, rarely severe, and also yielding to aspirin.

Pyrexia.—This has been seen frequently, the temperature usually ranging from 100 to 101 after operation, and dropping gradually by easy stages to normal on the second or third day. It has, apparently, no pathological significance.

Vomiting has occurred in one or two cases, usually within an hour or so of the completion of operation: in one, the removal of a large abdominal tumour, the dragging on the pedicle, and the displacement of the abdominal contents probably accounted for the sickness; in two, it was clearly due to the drug.

Other complications which have been at times hinted at, such as stiffness, recurrent paresis, disorders of vision, mental disturbances, insomnia, exaggeration of knee-jerks, renal, bladder and rectal disorders, although very carefully watched for, have not been noted in any instance.

It has not, I believe, been determined how the drug is eliminated, nor do I know of any work having been done in this direction. So highly complex a body is probably destroyed, or split up and excreted in various ways; in any case, so minute a dose would probably be extremely difficult to trace.

It has been suggested that stovaine forms a definite combination with nerve tissue, but the proofs of this seem to be entirely lacking; the comparatively rapid disappearance of analgesia, and the absence of any permanent after-effects, are entirely against such a theory. The action of the drug is probably a purely local one upon the posterior and, to a less extent, upon the anterior nerve roots. It is comparable to the action of cocaine upon the nerve trunks, as demonstrated by Cushing, the difference being in method only; in spinal analgesia stovaine is applied to the *roots;* in Cushing's method, cocaine is injected into the *trunks*, which have been dissected out.

The only reasonably probable danger of spinal analgesia would seem to be that of spinal meningitis, and this in careful hands must be very slight; certainly no greater than in lumbar puncture for diagnostic purposes. It can only be due to infection of the needle by the patient's skin; to improper sterilisation of the needle itself, or to the solution used. The remedy in the first and second of these is obvious, and the solution, when prepared by well-known firms, is little likely to be a danger. I know of no case in which such a disaster has occurred.

Advantages of spinal analgesia.—Besides the cases mentioned above, in which the method is indicated, there are others in which it will be found to have immense advantages.

a. Before all others may be mentioned the abolition of shock. Not only can spinal analgesia be used where shock is already present, but in cases where from the nature of the operation it is to be expected, such as double amputation, amputation at the hip-joint, prolonged excisions of the rectum, extensive enterectomies, hysterectomy, etc., it will get the patient over this grave danger if given prior to operation, even where a general anæsthetic is to be used. The influence of general anæsthetics in minimising shock must be admitted, but it is undoubtedly feeble, and is in no way comparable to that of spinal analgesia, which completely abolishes it.

b. The fact that there is no necessity to wait till analgesia is complete before the preliminary toilet of the operation is commenced, is a point in its favour as compared with general anæsthesia, and especially so with chloroform.

c. Again, where a skilled anæsthetist, or indeed any anæsthetist, is not available, spinal analgesia enables many operations to be done nevertheless; and in country practice this is often a matter of great importance.

d. In cases such as operations for hernia, where the vomiting following general anæsthesia throws a great strain on a part where such

strain may mean the failure of the whole operation, the danger is entirely obviated.

e. The occurrence of anæsthetic pneumonia is done away with.

f. The preoperative starvation and the postoperative anorexia incidental to general anæsthesia is no longer necessary, as the patient can feed before, during or immediately after the operation; and this is a very important point in the aged and feeble.

g. During an operation it may happen, especially in abdominal cases, that the surgeon may wish to question the patient; to obtain permission to some step not previously contemplated; or to advise him to accept some modification of the operation. Such proceedings would be impossible under general anæsthesia.

h. The patient, on his return to bed, being perfectly conscious, is able to do many things for himself which would otherwise require the constant attendance of a nurse. Consequently the strain on the nursing staffs, especially of smaller hospitals, is greatly minimised.

i. Lastly, the cost of stovaine is very much less than that of chloroform or ether, and as far as is at present known, it will keep indefinitely, which is far from being the case with the drugs mentioned.

Disadvantages.—These are few in number, but important. Firstly, the method cannot, in the present state of our knowledge, be utilised for operations at a much higher level than the umbilicus. Secondly, although ideal for all perineal operations in men, in sensitive women the position necessitated by such operations is incompatible with the retention of consciousness. Thirdly, it may occasionally be impossible, owing to the presence of septic ulcers, bed-sores, or malformations of the spine, to enter the spinal canal.

As may be gathered from what has been already said, there is no reason why the administration of chloroform or ether should not be resorted to, if necessary, after the injection of stovaine; in the cases in which this has been done, nothing has arisen to suggest that the practice is in any way dangerous.

I have been asked many times by general practitioners whether spinal analgesia can be used in obstetrical practice. On this point I have no personal experience, but the following extract from Merck's reports summarises the opinion of Chartier, so I give it for what it is worth:—

"Spinal injections of stovaine, not exceeding ·025 gm., were seen by Chartier to suppress the sensitiveness of the uterus to pressure, and at the same time stimulated contractions of the uterus, which occasionally led up to tetanic spasm enduring for ten to twenty minutes. The action of the medium continued for three-quarters of an hour to one hour. Chartier noticed, in six out of eleven cases, violent headache, giddiness, nausea, and vomiting to follow the administration of stovaine. He ascribes these symptoms to a pronounced sensitiveness in pregnant women with respect to the lumbar injection of stovaine, but does not regard them as fraught with danger. Stovaine is, however, contraindicated in the presence of internal versions, or when surgical measures are adopted in pregnancy, owing to its labour-inducing properties."

From the above, it would seem to have an entirely different action on uterine from that which it exhibits towards voluntary muscle, and in suitable doses might prove of value.

As regards the department of the anæsthetist, I would like to say a word. There is no doubt that spinal analgesia has a very great future before it. Dean goes so far as to class its discovery with that of antiseptics. Already the public is interested in it, and are requesting its use, as I know from personal experience. This being the case, it is a matter of the highest importance to the anæsthetist to adopt it without delay, if he does not wish to lose control of its administration. That it should be in his hands is right and proper; firstly, because it is part of the science of anæsthetics; secondly, because the surgeon does not desire, nor has he the time, to carry it out personally; and lastly, because, if for any reason the administration should fail, as it at times may do, a general anæsthetic must take its place. For this reason alone, even if in the future the whole body is successfully brought within its scope, spinal analgesia should be placed under the ægis of the anæsthetist.

Appointments.

Civil.

Cole, Percival P., F.R.C.S. Eng., has been appointed Sub-Warden of Queen's College, University of Birmingham.

Pollard, G. S., M.R.C.S., L.R.C.P. Lond., has been appointed Assistant Medical Inspector of Schools for the Frome District of Somerset.

Naval.

The following appointments have been posted at the Admiralty:—

Fleet-Surgeon Horace B. Marriott, R.N., to the *Doris;* Surgeon Harold G. T. Major, R.N., to the *Donegal;* and Surgeon H. B. German, R.N., to the *Vengeance.*

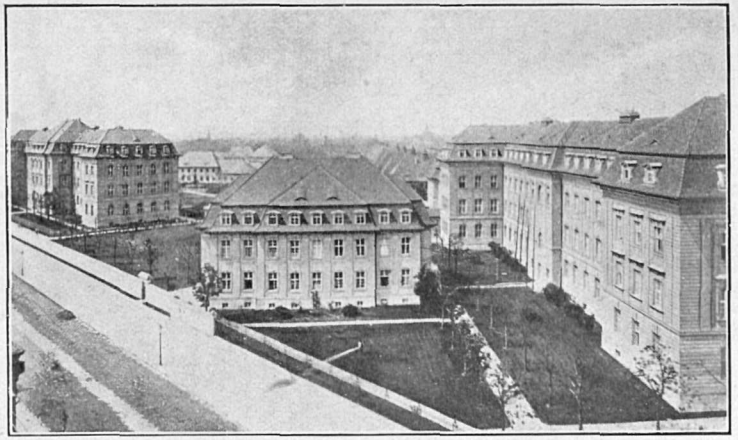
Notes of a Roving Guy's Man.*

II.

There are certain aspects of German surgery that strike the student who is accustomed to English and French methods of operation as being specially worthy of notice. On the whole, and regarding not merely individual methods which here, as elsewhere, differ widely, but those generally accepted, it may be said that operations here are less elaborated in theory and more elaborated in practice. This is by no means a paradoxical statement, and to make my meaning clear I may refer to the many complicated operations which German surgeons have devised and practised on the cadaver for the treatment of caput et collum obstipum. Some of these operative methods are indeed marvels of technical ingenuity, comprising as they do the removal of the scalene muscles, the stepping or myoplasty of the mastoids, and the creation of antagonising cicatricial contractures by the artificial shortening of the opposing muscles. None of these methods are in use, and the invariable rule now is to divide the muscle on the affected side subcutaneously—a return, in fact, to the practice advocated by Stromeyer. The treatment of wry neck of the congenital variety, in fact, is an excellent illustration of the methods of German surgery. To begin with, I am told that the congenital variety is uncommon here. Lorenz declares that in order of frequency it stands third in the list of common congenital affections, preceded as it is by congenital dislocation of the hip and congenital club-foot. With us that is certainly not the case. I doubt if many of us at Guy's ever see a case of congenital hip luxation, whereas congenital torticollis is fairly common in our wards. In the few cases I have seen here the affection was well demonstrated. The partial hemiatrophy of the face was pointed out (no stress, however, being laid on the fact that it is usually much better shown in a mirror or in a photograph), and more than half an hour was devoted to a very full discussion of supposed etiology and pathogenesis. The general view here seems to be that congenital wry neck is a "primary myogenic cervical scoliosis." The backward and upward carriage of the head is explained as being due to a primary retroflexion which has its seat in the atlanto-occipital joint, and a good deal of stress is laid on the deformities present in the base of the skull, leading to bony asymmetry due to pressure or to compression ischæmia. Von Eiselberg, however, has proved that there is no marked diminution in the volume of the vessels on the affected side, and has reported a case in which facial asymmetry and hemiatrophy developed in a girl of twelve, who had a cicatricial wry neck due to an extensive burn. The discussion of the theories of causation was interesting enough, though it gave one no new points. The hereditary theory, that it is due to pathological changes in the ovum, seemed to find some favour. The other views discussed were Schmidt's (which alleges that the deformity is due to the pressure of the mother's liver against the head of the child), Petersen's (which ascribes it to temporary intra-uterine adherence between the skin of the face of the fœtus and the amnion), Volcker's (which introduces "intra-uterine ischæmic contracture by shoulder pressure"), Dieffenbach's (that it is due to rupture of the sterno-mastoid—an obviously untenable theory, as congenital wry neck is present in cases in which no rupture has taken place, and fails in cases where a well-marked traumatic sterno-mastoid hæmatoma exists at birth; while to clinch the matter, Lorenz has shown that division of the fibres of a muscle—as in adductor myotomy for congenital hip luxation—invariably leads to lengthening instead of shortening), and Keder's (that it is really a "myositis interstitialis fibrosa traumatica" due to pathogenic organisms). Mr. Golding-Bird's theory (that it is due to a circumscribed encephalitis) was apparently not known. The differential diagnosis was very fully discussed, great stress being laid on the importance of eliminating Landolt's ocular torticollis before the case is accepted as a congenital wry neck. I was far more interested in the treatment than in the academical discussion of problems of causation, and on finding that the subcutaneous method was approved of, elicited an interesting *résumé* of the results of operative treatment so far. The mechanical methods, which are still in favour in Italy, where I saw such cases treated with Sayre's bandage on the "eccentric suspension" method, have been given up here as with us. Subcutaneous myorrhexis, introduced by Lorenz some years ago, is done with excellent results in some cases. Subjects suitable for this treatment must be very young children, and the attempt to lacerate the fibres of the muscle must be made very gently, more by manipulation than by actual force being applied, else clavicular dislocation and fracture may result. The operative methods now in use here are Volkmann's resection—*the* operation with us—Beyer's myoplasty, and Wullstein's operation, which consists in doing a Volkmann on the affected side and shortening the sterno mastoid on the other side. None of these methods are viewed very favourably, and the general opinion seems to be that the old subcutaneous division of the muscle (Stromeyer's operation) is after all the best. Lorenz, who has tried the open method very fully, has now gone back to the subcutaneous method, and his example has been generally followed here. The dangers of the "closed" method are said to be more theoretical than practical: the tense muscle efficiently protects the vein. In all cases the after-treatment by massage and a plaster neck splint is recommended, and it is said that so far this method has been most excellent, no bad results following. I saw a case that had been operated on a year ago, but I cannot say that the result seemed to me to be better than that which is almost invariably obtained at Guy's by Volkmann's method, except in so far that no scar is perceivable. In the spasmodic variety, I am informed, Hoffmann's operation (cervical neurectomy) is the usual operation in cases which have not

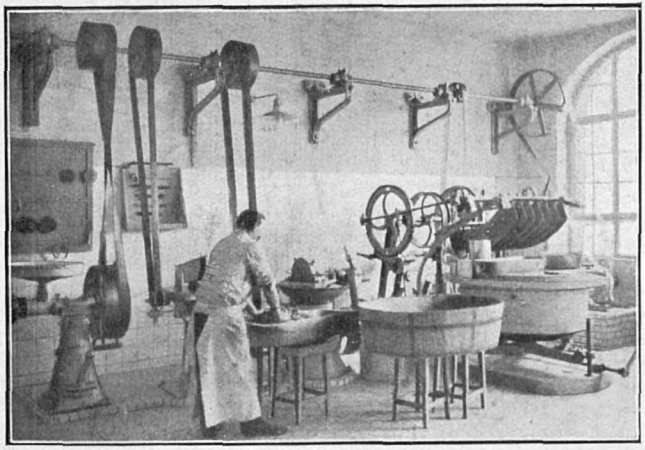
* 1st Series of Notes appeared in GAZETTE of April 4th.

A Bird's-eye View.



Another View.

A View from the Park.



The Sausage Room.

VIRCHOW-KRANKENHAUS.

Some Views of a Great Berlin Hospital.

benefited by palliative treatment, but the results are not very encouraging.

No one who follows the teaching here can fail to be struck with the amount of attention paid to pathology, and to theories formulated in the laboratory which have not been sufficiently worked out at the bedside, and often rest upon what Professor Allbutt has so aptly described as "clerk work." The "itch for writing a paper" is nowhere so evident as in Germany, and the amount of careful and laborious work expended on the production of ephemera is really painful to consider. To the practical student all this overweight of "literature"—for in science there is no distinction between "tripe" and "scoops," and everything stands a chance of acceptance in the German medical press, so long as it evidences some research—is annoyingly and exasperatingly inconvenient. One may have to glance through pages and pages of trash to find one fact worth noting. Nevertheless a great deal of solidly good stuff is turned out yearly, and the man who can collate all this and make the task of reference easier for the student who has no time for extended reading will deserve the gratitude of many. The post-mortem rooms are usually very fine. The one here at the Charité is more or less old, but still far superior to ours at Guy's. It bears above the door the somewhat trite sentence, in huge gold letters, "Hic est locus ubi mors gaudet succurere vitæ"—by no means so true an axiom as the cynical phrase which is to be seen above the *viva voce* room at Leyden—"Lasciate ogni speranza, voi ch'entrate!"

At the palatial Virchow the *Obduktions halle* is really a Versailles among post-mortem rooms, and, as Bell may be interested to hear, the attendant has his own little flat, with kitchen attached, above it. As a matter of fact the staff and attendants at the various hospitals are very well catered for. At the Virchow, they all have rooms on the premises, even the porters possessing their little lodges. The assistants have each a bed and a small sitting room, generally close to the wards, though not in the same building. The assistants have a good diet scale, and the food served out is far superior to any the College can boast of. There is the usual early breakfast of coffee and rolls, followed by lunch, which is a pretty solid meal: tea in the afternoon, and dinner at five or later, with supper at ten. Those on night duty have the privilege of getting beef-tea and rolls or milk from the kitchen. Most of the hospitals here, as in Germany generally, are really Infirmaries, under the control of the Town Council. This borough supervision appears to work very well. Scandals, as we know them, are not met with,* and there is no stinting in the way of instruments, bandages, etc. In fact, coming from Guy's, where the H.S. and A.H.S. are supplied with a monthly reminder of the fact that expense is very much an object, in the way of the return issued by the office, and knowing the keen eye that is kept upon supplies in French and Italian hospitals, I was astonished at the easy way in which bills were run up here. The celluloid splints, of which I gave an account in my last letter, bore away my total admiration, until I discovered that each costs, on an average, thirty shillings. I have crossed out celluloid plasters from my list of good things, and the homely Croft and Bavarians are reinstated in favour! Equally extravagant are the other methods in the polyclinics, for which the ratepayers have to provide the cost. No rectal or vaginal examination is made without a rubber finger-stall, a huge case of which is open to everyone; rubber gloves, Russian rubber shoes (costing from four shillings a pair), and rubber sleeves are provided almost *ad lib.* Dozens of overalls are used, the bandages are always white, the discarded forceps goes to the dust heap, not, as with us, back to shine in the historic instrument case, to cause the recording angel a bad half-hour when it is served out to her.

In the wards, equally expensive methods are in vogue. The cheap iodoform gauze has been superseded by the comparatively expensive vioform dressings; the catgut is dry, sterilised and patent prepared stuff. To a certain extent, instruments and dressings are far cheaper than with us, but even when that is taken into consideration, one stands amazed at what seems, after all, wilful and preventable waste.

I have spent several interesting mornings at Geheimrat Professor Bumm's clinic—the midwifery and gynæcological department of the Charité. The Geheimrat, who is the youngest of his order in Berlin (having qualified as late as 1880), is a kindly-looking old gentleman, with a deft, easy, operative manner. His operations are usually well attended, but he does not appear to "show off," and proceeds quietly and calmly, very methodically, with his work. The operation room is a moderately fine one, well lit and well ventilated, with several preparing rooms. The patients, who are lodged in a small ward next to the operating room, which is on the top floor away from the other wards, are prepared in one of these adjoining rooms. Lumbar anæsthesia by novocaine is invariably employed here at Bumm's clinic, though it is not general at Berlin. At the polyclinics and in most of the hospitals, local anæsthesia is largely used, and is employed even in cases of wide dissection of anal fistulæ with diverticula, stretching of the sphincter, hæmorrhoids, excision of tubercular and metastatic glands, opening empyemata, and a host of other operative procedures, which we effect under general anæsthesia. In fact, at one time it was thought that local anæsthesia would totally replace chloroform and ether (both of which, it may be mentioned, are here largely given in oxygen mixture apparatuses). Thus, Mikuliez, at Breslau, used cocaine anæsthesia for pylorectomies, gastrectomies, and cardiac œsophagectomies, not to mention such operations as intestinal anastomosis, and appendicectomies. He found, how-

* Perhaps not quite. This week, I am told, an "assistant" at a military hospital was court-martialled and sentenced to a period of arrest—six weeks, I think—for "negligence." A case had been sent in by an "out-patient officer," and the assistant, not deeming it sufficiently important for in-treatment, had sent the patient out, with the result that the man died in the street. Several professors stated in evidence that the assistant "ought to have recognised the gravity etc.," but house officers at Guy's will sympathise with the culprit!

ever, that it by no means diminished the post-operative dangers in such major operations, and shortly before his death he returned to his old and so well-defended favourite, ether. Here, however, local anæsthesia is very largely used. Newer fads, such as dioform, somnoform, etc., are deprecated. Morphine-scopolamine anæsthesia is sometimes used, especially at the large Jewish hospital, but the better modification, introduced by Abbott, in which scopolamine is replaced by the less dangerous cactin combined with hyoscine, is quite unknown here as in London. In some cases, of course, no anæsthetic is used. Removal of tonsils and adenoids, even in young children, is done without an anæsthetic; as with us, tonsillotomy is usually done, the perforating guillotine being used, not, as with us, the Mackenzie tonsillotome; tonsillectomy I have not yet seen performed, though it is frequently done. Bronchoscopy and œsophagoscopy, with Ewald's modified œsophagoscope, are usually done under local anæsthesia. The lumbar-puncture anæsthesia is, however, winning ground, though it is far from being so popular as in Paris and Lille, where 80 per cent. of operations are now done under it. This extensive use of lumbar anæsthesia seems to be entirely unjustifiable, and the German attitude towards it quite a reasonable one. Indubitably the mortality under spinal anæsthesia, up to the present, is far above that under chloroform anæsthesia (which, I am informed, averages here, for all the hospitals, one in 6,680 cases), even in the best hands, and to employ lumbar anæsthesia for operating on strangulated hernia or excision of varicose veins, as is done at Paris, seems almost a crime. For both these operations local anæsthesia suits admirably, and it is as unjustifiable to subject the patient to the risks attendant upon lumbar anæsthesia in these cases as it is to give chloroform in a case of extracting a single tooth, even though Mr. Barker states that with proper care those risks are negligible.

As it is used at Bumm's clinic, for major operations, lumbar anæsthesia undoubtedly has its merits. The patient is completely anæsthetic in her lower parts for an hour (the anæsthesia usually lasts from sixty to eighty minutes) and is quite conscious, can assist the surgeon in some ways (as in one case in which it was necessary to remove the uterus, when the Geheimrat stopped, explained the matter to the patient, got her consent to the removal, and proceeded with the operation) and there are few after-effects. The method of anæsthetising is sufficiently well known, and I need not stop to describe it.

The methods of operating at the Frauen Klinik differ in some way from those that prevail at other Berlin hospitals. The operator wears gloves, and so do his assistants. The Geheimrat, for instance, washes his hands in sterilised water, then in sublimate solution (biniodide and formalin are not used), and then again in sterilized water. This washing is very quick, hardly occupying five minutes, and after it the hands are thoroughly dried on a sterile towel. The gloves, which reach a good way up the arm, are sterilised and kept in sterilised talc, each glove having a linen dummy. They are handed out by the sister, the dummy is taken out, and the gloves slip on easily over the dry hand, the talc facilitating the process of pulling on. The patient is brought in and the operation commences at once, all the preliminaries having been done in the waiting room. The skin incisions, as is the rule here, are transverse, thus producing a valvular wound, cruciform in shape. In a case of myomectomy the incision was made from spine to spine, following in a curved fashion the outline of the pubic bones. This brought the operator down upon the origin of the pyramidalis and recti. The anterior wall of the rectus sheath was opened longitudinally and the recti split, showing the peritoneal reflection below. This was incised and the fibroid pulled up. The enucleation was as with us. Great attention was paid to sewing together the edges of the wound in the uterus, four layers of stitches being inserted. This, the Geheimrat explained, was his invariable method. One could not be too careful in sewing up the uterine wound, and all the former bad results of enucleation, which at one time threatened to ruin the reputation of myomectomy as the operation for choice in cases of fibroid, were due to faulty treatment of the enucleation site. The peritoneum, muscle, sheath and skin were then sewn up in layers, catgut being employed all through. No arteries were twisted, even the smallest bleeding vessel was picked up and tied with fine gut. The wound before being dressed seemed to be excellent. The dressing was vioform gauze and the usual bandage. This transverse incision is probably the first thing that strikes the newcomer, as it is used for all abdominal operations. It is said to lead to a very excellent firm scar, with no eventuation, but I have not seen any cases old enough to notice whether the scar has really been efficient. Some of the St. Petersburg men with whom I have discussed it say that they do not think its final results are quite so good as one would expect, especially when the wound is at the side, outside the limits of the recti. Various authorities claim the merit of having first used this transverse incision, but it has been used for quite a long time at Cracow and St. Petersburg. To be able adequately to discuss its merits one would have to see cases which have been operated upon years ago. Usually our longitudinal scars are firm and efficient enough during the first two years; it is only later on, when the patient passes out of sight, that ventral hernia becomes evident. The experience one gains as a dresser or H.S. is therefore apt to mislead, inasmuch as it tends to show that ventral hernia is exceedingly uncommon in patients leaving hospital. So it is, but if one looks up these patients later on, one finds that in many cases the scars that seemed so firm have yielded, either wholly or in part, resulting in a distressing eventuation. I have seen several such ventral herniæ in quite small scars, the sites of old appendicectomy incisions, and I really think that the risks of such eventuation are very much underestimated. It remains to be seen whether the transverse incision, which theoretically seems ideal, will give a better and more permanently efficient scar than the old longitudinal or oblique one.

At Bumm's clinic, asepsis is the order of the day, and in most of the operating rooms here a praiseworthy attention is paid to it. In some, the ritual reminds one of the stern practices that obtained at Breslau under the late Professor Mickulicz's *régimé*, where the precautions taken to prevent the entry of the dreaded and ubiquitous microbe really bordered on the ridiculous. No one was allowed to speak while the professor was operating; once you took up your place you were not permitted to change your position, for fear of raising "currents;" everything was handed to the assistant on a long pair of forceps, and, needless to say, everyone in the room had to wear not merely an overall, but cap, face-mask, goggles, gloves, linen trousers, and rubber over-shoes. One scarcely dared breathe in the Breslau theatre, where the environment was, in fact, equal to the solemnity of the aseptic ritual, for the rooms were built under the great surgeon's own superintendence, and were replete with the latest labour-saving devices. As I hear, they still insist on the aseptic uniform, but as the influence of the master is passing away, the Breslau school is permitting the unorthodoxy of talking while an operation is being done. Here in Berlin there is only one hospital—that at Schöneberg—where they insist on goggles. Filtration of air and the other refinements which one meets with at Paris, are not used; the "systems" exist, but they are not in operation, for, except at Schöneberg, it is recognised that absolute asepsis is a dream unrealisable in a large city. Many operators here do not wear gloves, and I have not found that their results are in any way worse than those obtained by the glove-wearing section. At Guy's, there is certainly no striking difference in the results obtained by those of our surgeons who wear gloves and those who operate without, and, in fact, one's experience is that the wearing of gloves leads to slovenly and careless cleansing of the hands, and that unconscious pricking of the glove by the needle in suturing, etc., is by no means an infrequent occurrence. It would be interesting to find out how many of the gloves we use at Guy's, for example, are absolutely sterile after having been worn by the operator for five minutes. Where a surgeon has to do a septic operation, the wearing of gloves is, of course, almost indispensable; but that is another matter. Here it is customary to "take cultures" at various stages of every abdominal operation, blood swabs or peritoneal fluid being usually taken. Where any pus is met with, this is at once examined, and a slide is brought up and shown to the operator. Thus, the first case I saw Bumm operate on was a woman with a large right-sided pelvic tumour, fixing the uterus, globular, and firm in consistency. The patient had had a "tumour" removed from the left side about two years before. A vaginal hysterectomy was done, and the adneya removed as well, a moderately-large ampullary tumour being removed, which was full of muco-purulent fluid. A slide preparation showed numerous gonococci, and the diagnosis of gonorrhœal salpingitis, made previous to operation, was thus confirmed. There is usually a fine laboratory attached to each division in the hospitals here, and everything is minutely and industriously examined. The "preliminary examination" of tumours, so strongly advocated by Mr. Lockwood, is not done, however, it being regarded as too often misleading, and requiring far too laborious a technique. Ordinary frozen sections are much too thick for proper examination, and there is no time to embed the excised tissue in celloidin and cut it with the fine Leitz's microtome which each laboratory possesses. In a thick frozen section the real distinction between malignancy and ordinary inflammatory processes are exceedingly difficult to demonstrate, and for that reason, mainly, the routine examination of tissues as a preliminary to radical operation has been given up.

Some of the best surgery to be seen in Berlin can be witnessed at this clinic, where the visitor is given every opportunity of criticising and comparing methods if he chooses. Like other schools, the Bumm folk have their likes and dislikes, but on the whole their methods agree very closely with ours, except in the matter of plugging the vagina to induce labour. Such lamponade, in opposition to the Dublin school, they strongly condemn. Their use of mechanical dilators—of which the Frommer-Bossi type with eight blades, instead of the original Bossi with four, is invariably used—is limited to primiparæ, and symphysiotomy, either during pregnancy (as is still done at Freiburg) or during labour, is condemned as antiquated and useless. Hebeosteotomy, or pubiotomy, is, however a favourite operation. A specially-curved needle is passed round the pubic ramus, between the periosteum and the bone.* This needle is furnished with an anterior groove which runs the whole length of its convexity, and serves for the passage of the Gigli's saw with which the bone is cut. Properly performed, pubiotomy is said, in selected cases, to be a very useful operation. The warnings on which Bumm lays stress are: that the operation should only be done if there is a chance of extracting a live child; for the extraction of one already dead it is "criminal" to subject the mother to such an operation; that the operation is only advisable in better-class women, and is emphatically contra-indicated in working-class patients who have to earn their own living, since the sacro-iliac synchondroses are rendered instable by it, and may even be dislocated. An interesting series of X-ray photographs at the clinic serves to show very clearly that the divided bone never unites by new bone formation, but always by merely fibrous union, notwithstanding the fact that great care is taken in the after-treatment, and that there is sometimes even a certain amount of overlapping. The operation, therefore, permanently weakens the pelvic girdle, by loosening the *ties*, and the effects of such weakening are admirably demonstrated in Mr. Morris' little monograph on joints. Lesser disadvantages of the operation are the possibilities of wounding the bladder,

* This is certainly fiction to a very large extent. In the dead subject, as I have found, it is exceedingly difficult to keep the needle between the periosteum and the bone, although theoretically it ought to be easier than on the living. I do not believe that the needle is ever kept rigidly between the bony and periosteal layers, but the deviation inwards and backwards is usually slight, and certainly does not warrant the catalogue of dangers which the opponents of pubiotomy have drawn up.—C.L.L.

of blood extravasation, and finally of sepsis. Cæsarean section, both by the ordinary method and by Bumm's "extra-peritoneal route," is very often done, and the combined statistics at the Frauen Klinik here give a mortality of 2-7 per cent. for the operation. Its performance does not offer any noteworthy points of difference from the method in vogue with us, with the exception, perhaps, that the patient receives rather a high dose of ergotin before the first incision is made. Great care is taken in suturing the uterus, and all bleeding vessels are most carefully tied before the skin incision—a transverse one—is closed.

The wards at the Frauen Klinik are scrupulously clean and have a pleasant, almost homely, aspect, which compares very favourably with Queen and Victoria. The nurses and sisters, who here, as in all the Berlin hospitals, act as instrument dressers at the operations, are very well trained and have to go through a special course before they join this part of the Charité. As instrument dressers they are certainly very efficient, knowing the names of the various modifications of instruments used, and being prompt and quick in threading, handing swabs, forceps, etc. The theatre sister and her two assistants have charge, usually, of a very fine and complete set of instruments—the cases at the Virchow operating room, for instance, remind one of Messrs. Down Bros.' exhibition room—and they manage to keep the armamentarium in almost perfect order. At the out-patients they do a great deal of the bandaging, strapping, Unna's pasting and other things—an arrangement which will certainly have the approbation of every assistant surgeon's dresser at Guy's after a hard afternoon's work in the strapping room!

There are, of course, many interesting questions in general surgery on which one might contrast and compare English and German methods did space and time permit of such comparison. A few outstanding points, however, in which German work appears to be in advance of our own, may be alluded to. Easily first of these interesting points is intra-thoracic surgery, by which I mean not merely lung surgery, but operations on the viscera lying in the mediastina and in the thorax. As an example, one may take carcinoma of the œsophagus. As every student knows, the seats of election of this by no means rare lesion are at those points where, through pressure or embryonic causes, the lumen of the œsophagus is slightly constricted—at its commencement, at the bronchial bifurcation, and at its passage through the muscular ring in the diaphragm. Statistics show that lesions of the "untouchable part"—that is, below the first dorsal vertebra—are as frequent as lesions in the upper or tracheal portion which has been totally resected (I believe as early as 1860) for a new growth. Hitherto, however, surgeons have fought shy of touching the lower portion, although attempts have been made to approach it from below, by way of the stomach (Loretta, Quenn and others), or from the side deep down below the clavicle. In these attempts the Italians took the lead, but their results were so poor that nothing more was heard of the matter till the late eighties, when the Germans took it up once more. Czerny, Billroth, Mikulicz, Hildebrand and Kraske, of Freiburg, worked at the subject, and laid down the principles for the new operation, "œsophagectomy by the posterior route," and in 1899 no less than sixteen cases had been operated upon—all unfortunately with a fatal result. The best case was that of Czerny, in which the patient survived for more than a year, but none of the cases were really "middle or inferior gastrectomies," and they all concerned the upper or approachable end of the tube. The results, however, led to more work being done, and in time the lower portions of the œsophagus were attacked, by laying open the posterior mediastinum, by resecting two or more ribs, and directly attacking the growth there. This, the radical operation, has now, thanks to the efforts of Mikulicz, and Gluck, gained a footing in the therapeutics of œsophageal cancer, although the results have so far been most discouraging, chiefly owing to the fact that cancer of the lower portion of the œsophagus is usually diagnosed at a very late stage when surgical interference holds out very small hope of success. On the cadaver a posterior œsophagectomy is by no means a difficult operation, although it demands a great deal of care and attention to detail. It is possible, as anyone who is interested in the subject can try for himself by experimenting on the remains left after the operative class above the pickle room has finished its work, to excise large pieces of the tube and to join the ends by invagination without laying too great a strain upon the œsophagus. With care, the immediate relations—pulmonary, carotid, and subclavian arteries, aorta, thoracic duct, vena azygos vein, and the recurrent laryngeal nerves—are easily avoided, though the vagus itself, especially the left, is usually cut. On the dog the operation is equally successful, though the two cases which I have in mind did not do well owing to the fact that in both pericœsophageal abscesses developed. As a matter of fact, operations on dogs by expert operators working thoroughly aseptically have had very excellent results, especially lately under the modified methods where the operation is done in a pressure chamber. But, as German surgeons admit, operations on animals prove little. "Die Kenntnis wie der Mensch auf einen bestimmten chirurgischen Eingriff reagirt Kann uns nur die klinische und pathologische Erfahrung am Menschen selbst geben"—a dictum which is specially worthy of notice, as it was expressed by one who has done a large amount of vivisection experiments. And in the living subject posterior œsophagectomy is no longer the simple operation it is on the cadaver or on the dog. The parts are matted together, the relations obscured and often involved in growth, and it is exceedingly difficult to avoid opening the pleuræ or injuring important neighbouring structures. Too much stress, perhaps, has been laid on the last point. Cut nerves may be sutured, after all, and injury to the thoracic duct or carctid is not irreparable, but the main dangers, which are really post-operative, remain. They are pericœsophageal abscess, empyema, gangrene of the lung, and the risk of the sutures

cutting through, not to mention shock. This last must always be a very grave danger in this operation, and the fact that hitherto no patient has survived the operation more than a few hours has very greatly discouraged some operators. Thus Prof. Hildebrand declares that he considers posterior œsophagectomy unjustifiable. But the recent improvements in œsophagectomy hold out very great hopes for the future. Posterior œsophagotomy, for removal of a foreign body, is a recognised operation, and the employment of the Sauerbruch's pressure cabinet is another aid which older surgeons did not possess. Here, at least, the feeling appears to be that given an early case where the growth is localised, freely movable, and the patient still in moderately good condition, the operation is feasible, and ought to be tried. The real crux of the matter is, therefore, early diagnosis, and such the employment of the œsophagoscope ought to realise. The newer instruments (such as are figured in the recent catalogues of Fischer, of Freiburg) are certainly excellent, and leave little to be desired. With Ewald's modification, for instance, gastroscopy is practicable, and the diagnosis between ulcer and multiple submucous hæmorrhages (gastrostaxis) should not present difficulty to an expert.

C. L. L.

Berlin, March 28th.

Nursing News.

Matron's Office.

On March 7th, Miss Beardoe Grundy, Sister Naaman, resigned her post of Sister, which she had held since January, 1899, to take up her new duties as Out-patient Visitor. Sister Muriel, Miss E. M. Cheesman, who had been Sister in Charge of the Wardmaids, was transferred to Naaman, and Sister Edith, Miss E. Wallis, the Night Sister, was appointed Sister in Charge of the Wardmaids.

On March 19th, Sister Clinical, Miss Strick, who had been a Ward Sister since 1886, left the Hospital to take a short holiday previous to taking up her duties as Lady Superintendent, of the Guy's Trained Nurses' Institution. Sister Queen, Miss E. Densham, was transferred to Clinical; Sister Ida, Miss I. Cornwell, from the Light Department, to Queen; and Sister Ethel, from the Nurses' Home to the Light Department.

Mrs. Higgens, who had been acting as temporary Night Sister for some months, left the Hospital on March 16th. Sister Eleanor, Miss E. Jolly, was transferred from the Training School to night duty; Sister Theatres, Miss J. Crerar, was transferred to the Preliminary Training School; and Miss E. Edwards, who completed her training in April, 1907, was appointed Probationary Sister in charge of the Theatres.

Miss Elsie Fraser, Sister Out-patients, who has resigned her post to take up nursing abroad, left the Hospital on April 23rd, and Miss M. J. Lyons, who has just completed her training, has been appointed Probationary Sister in the Out-patient Department.

On March 12th, Nurse Lefebvre, Head Nurse in Luke, left the Hospital on completion of her three years' training, and Nurse Grierson was appointed to succeed her.

On April 1st, Nurse Canter left the Hospital on completion of her three years' training, and Probationer Levis was appointed to succeed her as Head Nurse in Bright Ward.

Nurse Tandy, Head Nurse in Bright, also left the Hospital on completion of her three years' training, on April 7th, and Probationer Hancock was appointed to succeed her as Head Nurse in Bright.

On April 11th, Nurse E. C. Jones left the Hospital on completion of her three years' training, and Probationer Jefferson was appointed to succeed her as Head Nurse in the Theatres.

On April 15th, Nurse Rae, Head Nurse in Charity, left the Hospital on completion of her three years' training, and Probationer Hickman was appointed to succeed her as Head Nurse in Charity.

On April 24th, Nurse Hogg was transferred to the Theatres as Head Nurse, and Probationer Harrington was appointed to succeed her as Head Nurse in John Ward. Probationer Kiddle was also appointed Head Nurse in Miriam Ward.

Nurse Hambro, Head Nurse in Bright Ward, left the Hospital on April 30th, on completion of her three years' training, and Probationer M. Hill was appointed to succeed her as Head Nurse.

Reviews, etc.

The price of books submitted for review should in every case be stated.

Dental Histology. By A. Hopewell-Smith, M.R.C.S., L.R.C.P., L.D.S. (Dental Manufacturing Company, Limited.) Pp. 663, 2 vols. Price 18s. net.

This work is an excellent one in many ways. It is divided into two volumes, Volume I. comprising the normal histology of the teeth and their development, with a few remarks on the mouth and salivary glands. Volume II. deals with the pathological conditions of teeth, the bacteriology of the mouth, and the common malignant tumours of the gums and jaw. A few words on dermoid teeth complete the book.

The book is well written, and fairly full numerous footnotes to original papers are given for those who wish for fuller information.

A characteristic feature of the work is the large number of micro-photographs used as illustrations, and on this point we would quarrel with the author; at least one half of these should be replaced by drawings and diagrams. There is still the idea abroad that photographs cannot lie. They do. We have no doubt Mr.

Hopewell-Smith's sections are better than his micro-photographs, and in the case of high power ones, at any rate, a good drawing would be much preferable.

We cordially recommend the book to our readers.

Questions and Answers upon Ambulance Work. By John W. Martin, M.D. 16th Edition. (Baillière, Tindall & Cox.) 1s. net.

This edition brings this well-known little catechism into its sixty-second thousand. The book is a concise supplement to the St. John's Ambulance Association's official text-book (Shepherd's), and is intended not only to be an exam. book for ambulance workers, but also to give to the medico who holds lectures and classes some idea of the ground he should cover. We are pleased to see that the author has not fallen into the error which some of the more recent text-books have displayed; that is, entering too deeply into the subject treated of, with the result that it is impossible for an ambulance-class lecturer to cover the ground in the specified seven lectures.

Essentials of Human Physiology. By D. Noel Paton, M.D., F.R.C.P. Edin. (Wieldam, Green & Son.) Pp. 477. Price 12s. net.

This is the third edition of the work, and it has been revised and several parts re-written, especially the section dealing with proteins. A feature of the book is the large amount of space devoted to the musculo-nervous system. In our opinion the other branches of the subject suffer from this extravagance. But in the limits of the space given, the subject is well if succinctly treated. Some of the illustrations are particularly good. It is a good book for the student of elementary physiology, being concise and lucid.

Journals received:—Union Magazine: Medic. Temp. Review; The Hospital; The Clinical Journal; S. A. Medical Record; Middlesex Hospital Journal; Polyclinic; St. Bartholomew's Journal; Durham College of Medicine Gazette; London Hospital Gazette; St. George's Hospital Gazette; New York State Journal of Medicine; Calcutta Medical Journal; St. Thomas's Hospital Gazette; Manchester Medical Students' Gazette; The Prescriber; St. Mary's Hospital Gazette; The Practitioner; Le Mois Medico-Chirurgical; Journal of Balneology and Climatology; West China Missionary News.

From the Gazette's Special Pathologist.

G. M. J., Alton.—No tubercle bacilli are found in the films prepared from this specimen.

G. E. H., Ramsgate.—This specimen of sputum was muco-purulent in character, but no tubercle bacilli were found in it.

PATHOLOGIST.

Papers by Guy's Men.

Pneumococcal Otitis Media. By W. H. Bowen, M.S. Lond., F.R.C.S., Eng.—*West London Medical Journal* for April, 1908.

Certain Infections of the Urinary Tract, with special reference to Tubercle, Gonococcus and Bacillus Coli Communis. By G. Leslie Eastes, M.B., B.Sc. Lond.—*The British Medical Journal*, 25th April, 1908.

Persistent Hereditary Œdema of the Legs, with Acute Exacerbations—Milroy's Disease. By W. B. Hope, M.R.C.S. Eng., L.R.C.P. Lond., and Herbert French, M.D. Oxon., F.R.C.P. Lond.—*The Quarterly Journal of Medicine*, vol. I., No. 3, April, 1908.

On So-called Rheumatic Iritis. By C. Higgens, F.R.C.S. Eng.—*The Lancet*, 25th April, 1908.

A Case of Belladona Poisoning. By H. Knight Rayson, M.D. Brux., M.R.C.S. Eng., L.R.C.P. Lond.—*The British Medical Journal*, 25th April, 1908.

Hunterian Lectures on the Anatomy of the Long Bones Relative to Certain Fractures. Lectures I. and II. Illustrated. By Ralph Thompson, Ch.M. Viet., F.R.C.S. Eng.—*The Lancet*, 18th and 25th of April, 1908.

BOOKS AND JOURNALS RECEIVED.—Medical Annual for 1908; Harman's Aids to Ophthalmology; Murray's Hernia; Compton's Essentials of Surgery; Harris' Electrical Treatment; West London Medical Journal for April, 1908; The Birmingham Medical Review for March, 1908; No. 31, Scientific Memoirs, Government of India—The Development of the Leishman-Donovan Parasite in Cimex Rotundatus.

Change of Address.

Dr. H. V. Hickman, from Overton House, The Mall, Wanstead, to The Hollies, Wanstead.

Dr. C. E. Iredell, from Guy's Hospital to 41, Devonshire Street, Portland Place, W.

Dr. J. H. Jones, from 89, Castlereagh Street, Sydney, N.S.W., to Bligh Chambers, 10, Bligh Street, Sydney, N.S.W.

Dr. Allen P. Piggott, from Whitecroft, Carisbrooke, Isle of Wight, to 26, Cloudesdale Road, Balham, S.W.

Dr. R. J. Reynolds, from 11, Brixton Hill, S.W., to Rossendale Lodge, 17, Streatham Hill, S.W.

Dr. George Turner, from Department of Public Health, Transvaal, to Auchinclech Cottage, Skene, Aberdeen.

Deaths.

DAGLISH.—On April 23rd, at New Romney, Kent, Richard R. Daglish, M.R.C.S. Eng., L.S.A., J.P., aged 66 years.

WASON.—On April 20th, Lancelot Llewhellin, only child of R. L. Wason, 2, Burgoyne Road, Harringay, N., aged 8 years and 9 months.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

May.

Sat. 16. 1st XI. v. Sevenoaks (Away).
2nd XI. v. Old Olavians (Away).

Mon. 18. Special Clinical Lecture, 1.15 p.m.

Wed. 20. July Appointment (Dental) List opened.
1st XI. v. Hampstead (Home).
2nd XI. v. St. Thomas's Hospital (Away).

Thur. 21. Annual Meeting of the Dental Society, at 8 p.m.
Mr. Golding-Bird's and Sir Alfred Fripp's Take-in commences (Messrs. Flower and Cook).

Sat. 23. 1st XI. v. Reigate (Away).
2nd XI. v. Granville "A" (Home).

Mon. 25. Special Clinical Lecture by Mr. Targett, at 1.15 p.m.

Tues. 28. July Appointment (Dental) List closed.

Wed. 27. 1st XI. v. R.A.M.C. (Home).
2nd XI. v. Manor House School (Away).

Thur. 28. Mr. Symonds' and Mr. Steward's Take-in commences (Messrs. Stebbing & Henderson).

Passim.

ALL Guy's men, both past and present, will be pleased to hear that Sir Samuel Wilks, who has lately undergone an operation, is making excellent progress. Mr. Symonds, a fortnight ago, performed a prostatectomy—the whole of the right lobe and most of the left being removed by the perineal method—for painful and frequent micturition. Immediate relief followed the operation, and the patient is now taking his food and sleeping well. Dr. Jessop, his old friend and neighbour, is in constant attendance. Sir Samuel, on the second of next month, will complete his 84th year. That his interest in his old school is as keen as ever we have just had remarkable testimony; for, as will be seen in another paragraph, he has been so good as to correct an inaccuracy which appeared in our Passim of last number. We hope his convalescence will be rapid and unbroken, and that he will be amongst us for many years to come.

IF a falsehood is allowed to be repeated time after time and never contradicted, the natural sequence is, people in time come to believe it. This is, we fear, what has happened in many cases when anti-vivisectionists, with that callous disregard to accuracy of statement which is the general characteristic of the faddist, have been allowed to carry on their propaganda without any organised opposition from the medical profession. All who have the interest of science at heart will join with one voice in welcoming the Research Defence Society, which has quite recently been founded to meet anti-vivisectionists on their own ground, and vindicate the methods by which research is carried on. The aim of the Society—to quote from the letter of Lord Cromer in the *Lancet* of April 28th—is "to make known the facts as to experiments on animals in this country, the immense importance to the welfare of mankind of such experiments, and the great saving of human life and health directly attributable to them."

IT will be the work of this Society to give information to all enquirers respecting vivisection as it is carried out in this country; to

publish and distribute articles and leaflets in districts where anti-vivisectionist activity is much in evidence; to send speakers to anti-vivisectionist debates and meetings; and to carefully watch the papers and publish an answer whenever an anti-vivisectionist airs his grievances in the press. If this policy be diligently carried out, people will soon learn enough about the facts of the case to estimate anti-vivisectionists at their proper value; for it is only by trading on the ignorance and credulity of the masses that these eloquent faddists have won the support that has been given them in the past.

THIS Research Defence Society is by no means an association of scientists who might be suspected of having personal interest at stake in the controversy. Among the 1,100 members already enrolled, there are many bishops, artists, literary men, some Members of Parliament, and some prominent members of the Society for the Prevention of Cruelty to Animals. The annual subscription is 5s. to cover working expenses, but larger subscriptions will be gladly received. The Committee wish to enlist medical students as members, and it has been decided to reduce the subscription in their case to 2s. 6d. Every student who has the cause of science at heart, and who wishes that a much misled public should be apprised of the real aim of general research, should hasten to communicate with Mr. Stephen Paget, 70, Harley Street, W.

IT is difficult to express adequately the feelings of the nurses of Guy's Institution when they first heard that there was a possibility of their much-esteemed Lady Superintendent having to leave them. The news was received with great concern, as no one thought that an "age limit" could affect the unique position which the Superintendent holds. As soon as possible an urgent petition, signed by every nurse in the institution, was sent in to the Board of Management requesting that Miss Oxford might hold the post for a further period, but they could not see their way to comply with the nurses' request. The refusal gave the keenest disappointment, and cast a gloom over the institution. The years Miss Oxford has spent here have passed quickly and happily. No one could have held the post with more efficiency. She has always been just, tactful and considerate, ready to listen to their grievances (for private nurses have some!), and to give advice. Her broad-mindedness and her vast store of knowledge she has always been willing to use for the benefit of each individual nurse. The nurses will miss her kindly smile of welcome when returning from their cases, for she has always shown the greatest interest in their work. Her kindness to those who have had the misfortune to be ill will never be forgotten, and she has done much to make the "sick room" more home-like. They will miss, too, the bright face that looked into their sitting-room, saying, "Nurse So-and-So, I think *you* will do." She was delighted to send off her last nurse, with the remark, "You are my last hope, nurse!"

MISS OXFORD entered Guy's Hospital in 1886 and from 1887 to 1901 she held the appointments of Sister of Eye, Dorcas, Philip, and Clinical wards. She was held in great esteem by all who knew her. To work in her wards was considered an honour. She took great interest in her probationers and infinite trouble in training them. A good report from her carried weight and insured the Nurse's successful career. Whilst in the Hospital Miss Oxford held the post of Lecturer on "Nursing," and her book on the same subject is now the recognized text-book there. It has been translated into French and Italian. It was in January, 1901, that Miss Oxford was offered and accepted the post of Lady Superintendent of the Institution, the arduous and exacting duties of which she has performed with her usual energy and promptitude. She will be greatly missed by doctors and clients alike.

THE "Guy's Maternity Charity" also claimed a large share of her care, for she often visited the poor in their own homes, and satisfied herself as to their need of help. How delighted she

was at Christmas when a Nurse returned with a well-filled "collecting card" for the Children's Tea. Miss Oxford's interest in the Nurses has not ceased when they have left the Institute, but has followed them wherever they have gone. She is delighted when one of her Nurses gains a post of distinction, and watches her progress with pleasure. Before leaving the Institution, Miss Oxford was asked to accept a gold watch and chain from the past and present Nurses as a memento of the happy relations existing between them.

On another page will be found a letter from a correspondent anent the notes in Passim, of our last number, in which we drew our readers' attention to the question of the right of Diplomates of the Colleges to the title of Dr. He does not share our view of the value of the Conjoint Diploma, and quarrels with the statement that the Final is as difficult as *most* examinations which give the successful candidate the right to style himself Dr. That "most" is not a qualifying term of "uncertainty," but states what we firmly believe, for no one would place the qualifying exams. of many bodies—we will make no invidious distinctions—on the same plane as that of the London University. On this point we would like to refer him to an address by Sir W. Allchin, on some problems of Medical Education in London, which appeared in the *Academical Press* (1907). As for his remarks on initial general education and the standard of entrance examinations, we do not think there is any gulf of difference between the matriculation examinations of any University and the College of Preceptors examination. Of course, compulsory residence at a great seat of learning *may* benefit a man, but this applies to but two Universities, and, to say the least of it, it would be priggish to contend that this was a great factor in increasing the value of a University Medical Degree. No, our point is this, we do not suggest that anything should be done which will depreciate the value of a hard-earned University Degree, but that the Diplomate should be allowed by courtesy to use the title Dr., and that the fact that he is not a graduate of a University should not be a bar to Hospital appointments.

The Inter-Hospital Boxing, etc., Competition is to be held on Tuesday evening next, May 19th, at 8 p.m., in the People's Palace (East London College). Our representatives are—*Gymnastics*, L. Bromley and G. H. Hunt. *Boxing:* Featherweight, R. M. King; Light, L. Kemp; Middle, E. Rice; Heavy, A. H. Crook. *Fencing*, G. F. Haycraft. Mr. E. P. Minett will act as M.C. Tickets, 1/–, 2/6, and 5/–, are obtainable in the Smoking Room, or from Mr. G. F. Haycraft, the Hon. Secretary. We trust that there will be a good muster of our men present to assist the team in bringing the Cup to the South side.

It is remarkable how hard it is to kill an error. In our last number we stated that Keats abandoned the medical profession without taking any medical qualification. This identical statement was made by one of our predecessors in the Gazette of July 29th, 1905, and was duly corrected by a letter from Dr. Hale White in the issue of August 26th of that year. In the minute book of the Court of Examiners of the Society of Apothecaries, under the date of July 25th, 1816, occurs the following passage: "John Keats attended and produced testimonials to the satisfaction of the Court, and was admitted to the examination. Mr. Keats was examined by Mr. Brande, and the Court granted him the certificate for which he had applied." For this piece of information we are indebted to the kindness of Sir Samuel Wilks, who, amidst the trials following a severe operation, was thoughtful and kind enough to communicate with us.

On looking back to Dr. Hale White's letter in the Gazette (No. 449), we find that though he was a "diligent pupil," the Poet's mind was not always directly attentive at lectures, for in the note-book in which he kept the notes of anatomy lectures he attended at Guy's, appears this little flight of fancy: "The other day, during the lecture, there came a sunbeam into the room, and with it a whole troop of creatures floating in the ray; and I was off with them to Oberon and fairy land." He evidently at one time thought of following the profession, for we read that he was thinking of taking the post as

surgeon on an East Indiaman. Once again, too, speaking of the publication of "Lamia, Isabella, etc.," about nine months before he died, he says, "This shall be my last trial; not succeeding, I shall try what I can do in the apothecary line." Our thanks are due also to Dr. Hale White for drawing our attention to the error and its previous correction.

WE would like to draw the attention of our readers to Dr. Shaw's letter on page 186 of this issue. This year's Biennial Dinner promises to be a huge success, and we trust that no man who is able to avail himself of the opportunity will fail to be present. We have already pointed out in the pages of the GAZETTE the manifold pleasures which can be derived from the bringing together of old friends and colleagues for a purpose which is essentially one of a social nature—for, remember, the Biennial is *not* a function for the purpose of flaunting subscription lists! The idea of many vice-chairmen is excellent, likewise the suggestion of "putting up" for the night men from the country. Present students should note that they are cordially invited, and we trust many will take advantage of the invitation.

Papers by Guy's Men.

Traumatic Tetanus beginning with Clonic Spasms. By Edward Bigg, M.A., M.B.—*British Medical Journal*, 9th May, 1908.

Five Cases of Vesico-Vaginal Fistula. By O. J. Currie, M.B. Lond.—*Ibid.*

An Early Case of Intussusception. By Dudley G. Greenfield, M.D. Lond., F.R.C.S. Eng.—*Ibid.*

On the Pathology and Treatment of Inguinal Hernia in Children. By C. H. Fagge, M.S. Lond., F.R.C.S. Eng.—*The Lancet*, May 2nd, 1908.

Appointments.

Naval.

Fleet-Surgeon W. BETT, R.N., has been appointed to the *Leviathan*, and Surgeon R. W. B. HALL, R.N., to the *Enchantress*.

(Dr. Hall was on board H.M.S. *Gladiator* when she sank off the Isle of Wight in April last.)

The First Cases of Spinal Anaesthesia at Guy's.

BY W. M. MOLLISON, M.C., F.R.C.S.

UNTIL about three weeks ago Spinal Anæsthesia had never been practised at this hospital, so that the following five cases in which stovaine was employed may be of interest.

The method employed was the same in all cases; that used at University College Hospital, where Mr. Barker kindly demonstrated to me his procedure.

The patient lay upon his left side, the buttocks supported on a sandbag and the head well raised, so that the mid-dorsal region sank to the lowest part of the curved spine. A special hollow needle was introduced in the middle line between the spines of the third and fourth (or second and third) lumbar vertebræ—that is, at the level of the highest part of the iliac crests. After allowing about 2 cc. of cerebro-spinal fluid to escape, 5 centigrammes of stovaine in glucose were injected. The patient was then rolled on to the back, the head being kept well raised, and the buttocks still supported on the sandbag.

The first case was not fully successful, owing to inexperience, a want of confidence in the action of the drug, and a desire not to allow the cervical cord to be affected. The fifth case was, as far as the field of operation was concerned, a failure, and the cause of the final disposition of the anæsthesia was difficult to understand; in this case, too, the attack of collapse during the examination must be put down to the stovaine; as also the headache and vomiting afterwards.

SPINAL ANÆSTHESIA.

CASE 1.—Chas. C., æt. 58, was admitted into Clinical suffering from a perforated duodenal ulcer; as this was complicated by chronic bronchitis and dilatation of the heart, Dr. Hertz suggested spinal anæsthesia. The injection was made as described: in about three minutes the legs became anæsthetic, and after about seven to eight minutes the analgesia spread up to one inch above the umbilicus. Mr. Hughes operated, The incision was made above the umbilicus, that is, higher than the upper level of the anæsthesia. The man did not seem to feel the pain much; but when the peritoneum was reached the pain was considerable, and became severe when the stomach was pulled on. He was given gr. $\frac{1}{3}$ Morph. subcutaneously, and it was difficult to say whether the stovaine, the

morphia, or both, were responsible for his complete analgesia later while the wound was being sutured. He had neither headache nor unpleasant sensations in the legs after the anæsthesia passed off.

Case 2.—John M., æt. 52, was admitted into Clinical suffering from acute intestinal obstruction of five days' duration, with fæcal vomiting. Again, since on admission the patient was almost pulseless, Dr. Hertz suggested stovaine. After injections of saline he was brought on to the table, still much collapsed. After the stovaine had been given, the left leg first and shortly after the right leg became anæsthetic, and soon, too, the anæsthesia reached a little above the umbilicus. The operation was performed by Mr. Steward. The analgesia was perfect, the patient talked most of the time, and only complained that his arm was being hurt when an intravenous injection was being given. This patient died the next day, almost certainly as a result of the obstruction.

Case 3.—Fred. G., æt. 71. This man, admitted under Mr. Symonds, had previously had a general anæsthetic for amputation of the foot, and now was to have re-amputation below the knee for tuberculous disease in the stump. The patient was offered his choice of stovaine or chloroform, and chose stovaine. The left leg was anæsthetic within two minutes of the injection; the right soon followed. Anæsthesia was complete, and the patient had a long conversation with the onlookers during the operation. Subsequently he had neither headache, nausea, nor unpleasant sensations in his limbs. Thirty-six hours after the operation his temperature, for a few hours, fell to 95·6° F., which, it was suggested, was due to the stovaine, though there were no coincident symptoms, and his temperature had often fallen to 97 before the operation. It may be added that the patient was extremely pleased with the whole procedure, and said he preferred it to the chloroform.

Case 4.—Mary H., æt. 52, was admitted under Mr. Symonds into Lydia, suffering from a fractured patella on the right side; some years before she had had the left patella wired by Mr. Lucas.

Mr. Symonds suggested to the patient she should have stovaine, to which she agreed. The analgesia was perfect. The word analgesia rather than anæsthesia is used because the patient could tell what was being done to a certain extent, but felt no pain whatever—for instance, she knew that the skin was being sewn at the end of the operation, and that the bone was being pulled on when the fragments were being drilled.

Afterwards she had, perhaps, more pain in the knee than she would have had after chloroform. The operation was performed at 3 p.m., and she ate a hearty tea at 4.30 with no ill-effects.

Case 5.—Fred. F., æt. 17; admitted under Mr. Symonds. He was suffering from tuberculous disease of the bladder, and a cystoscopic examination was to be performed. After the injection, the patient's buttocks were allowed to sink by the removal of the sand-bag; this, apparently, was a mistake, as the anæsthesia practically failed entirely. The bladder was washed out, and the patient had a good deal of pain, though after a time he allowed eight ounces of fluid to be put into the bladder where previously only two ounces were tolerated. He also had some pain when the cystoscope was passed. Shortly after this, and about ten minutes after the injection, the patient had an attack of shock with retching, nausea and pallor, his pulse also becoming feeble; he was given five minims of liq. strychnine hypodermically, and soon recovered. Later the buttocks were raised, and at the end of the operation the pain in the bladder was less than at first.

Before the patient left the table his sensation was very carefully tested, and it was found that the anæsthesia had a most curious distribution. There was complete anæsthesia over the abdomen and lower part of the chest as high as the fifth rib, also over the whole of the left leg, while the right leg was perfectly sensitive except just at the highest part, in the groin. The right side of the perineum was sensitive, while the left was anæsthetic.

After-effects.—The patient had some headache for about two hours; during the next thirty-six hours he felt perfectly well; he then began vomiting persistently, and could keep no food down till four days later, when he tolerated small quantities of milk. During the first three of these four days he had bad headache and pain in the back. The eyes were examined by Mr. Eason, who found each fundus normal.

The boy was perfectly fit again by the fifth day.

Presentation.—On April 15th, Dr. A. H. Evans was presented with a handsomely chased and inscribed silver cake-dish, on behalf of over 100 patients of the Sutton Coldfield Medical Dispensary. Dr. Evans is retiring from active work in connection with the institution.—*Lancet.*

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Biennial Dinner, 1908.

DEAR MR. EDITOR,—I shall be greatly obliged if you will allow me to call attention in your columns to some details concerning the forthcoming Biennial Dinner.

The date has been fixed for Wednesday, July 8th, and the dinner will take place at 7 o'clock at the Hotel Cecil.

Mr. Charters Symonds will be the Chairman. The preliminary arrangements Committee have decided to make some alterations on the present occasion. In the first place, it has been agreed that a number of Vice-Chairmen shall be appointed, from groups of men qualified about the same period, each Vice-Chairman to preside over a separate table of his contemporaries, and to be requested to co-operate with the Honorary Secretary in promoting a large attendance at the dinner.

A Selection Committee was appointed to invite old Guy's men to act as Vice-Chairmen, and it has received a very satisfactory response.

The following have already intimated their willingness to serve, the names being arranged in order of seniority of qualification, ranging from 1861 to 1906:—

A. Roper, F. Manser, J. R. Bosworth, T. S. Townsend, W. J. Tyson, J. Mackern, H. Blatherwick, C. D. Muspratt, S. Wacher, W. C. Swayne, H. J. Holman, W. J. Scott, J. W. F. Jewell, E. E. B. Landon, J. J. E. Biggs, A. Allport, E. T. Shorland, E. Fisk, A. J. Cleveland, G. N. Mottram, W. R. Cazenove, T. P. Thomas, K. V. Trubshaw, F. D. S. Jackson, B. Glendining, H. M. Woodward, E. W. Sheaf, and H. D. Wyatt.

It has also been decided to facilitate arrangements for old Guy's men living in London and the suburbs to put up for the night, men coming up to the dinner from the country.

A change, which was decided only after very careful discussion, has been made in the manner of paying for the dinner. Hitherto a charge of 22s. or 23s. has been made to each person attending the dinner, this charge including wine. This year the charge for a dinner ticket will be 10s. 6d., exclusive of wine.

In view of complaints in recent years that the speeches tended to interfere with the interchange of greetings and conversation between men for whom the biennial dinner affords the only opportunity of meeting, it has been decided to follow the example of the Royal Academy Banquet, and as an experiment to dispense with speeches altogether on this occasion.

Before the next issue of the GAZETTE, the circular letter, inviting all Guy's men to make application that seats may be reserved for them, will be posted. It always happens, in sending out such letters, that some names are omitted, and from this and other causes some who see this communication may not receive the circular. I shall be greatly obliged if anyone who himself fails to receive a circular, or knows of any old Guy's man similarly neglected, will inform me in order that the omission may be remedied. We are particularly anxious to get into touch with any men usually resident abroad who may be visiting England this summer.

In accordance with the usual custom, the notices will not be circulated to present students, but may be obtained by them from the Librarian. I need not say that applications for dinner tickets from present students will be warmly welcomed by those responsible for the arrangements.

I feel sure, Sir, that I may rely on the kind co-operation of yourself and your numerous readers in endeavouring to make the Biennial Dinner for 1908 even more successful than these most successful dinners always have been in the past.—I am, yours sincerely,

LAURISTON E. SHAW, Hon. Sec.

64, Harley Street, W.

The Title of Dr.

DEAR SIR,—As you invite discussion as to whether other qualifications than that of "M.D." should carry with them the title of "Dr.," may I be permitted to put forward certain views on the question?

I do not think the statements in "Passim" are supported by facts. In the first place, I do not agree at all with the remark that a man who has gained the diploma of the Royal Colleges "has passed an examination which, at other centres, entitles him to a degree in medicine with the undoubted right of the title of M.D." This is much too sweeping a statement. As I am not acquainted with all the examinations for the M.D. degree, I cannot say that this may not be true of some. I have, however, myself taken the Conjoint Diploma and the M.D. degree of an English University, and I know that the M.D. degree of the University, of which I am a member, is much more difficult of attainment than the diploma of the Royal Colleges. So far as surgery is concerned, the examination at the College is quite as difficult to pass, but the medicine and midwifery examinations do not even approach the standard requisite for the M.B. or M.D. degree which I hold.

Even suppose that the whole examination were as difficult, the College examination can be passed in sections, and this fact alone would make it an easier examination than that for a degree in which all subjects must be taken at the same time.

Apparently the writer of "Passim" is not sure himself of the truth of the statement disputed above, as he qualifies his statement in the next sentence by the word "most." If, then, there are M.D. degrees which are more difficult of attainment than the College diploma, the value of these is depreciated by the fact that certain Universities grant degrees which are as easily obtained as the College diploma. Is this a reason for still further depreciating the value of these degrees by raising to the status of M.D. every diplomate of the Colleges? One would have thought that the holders of these more

valuable degrees had suffered enough already, without being called upon to suffer more.

Then, again, the argument based upon the results of the service examinations is utterly fallacious. The fact that a diplomate gains a higher place than a graduate does not prove that a degree is as easily obtained as a diploma: it only proves that the particular diplomate is a better man than the particular graduate. No doubt there are many diplomates who are as good or better at their work than the highest graduates; just as, no doubt, there are many diplomates who are as good at their work as many Fellows of the College. I have not yet heard it suggested that, because the latter is the case, all diplomates should assume the title of F.R.C.S.; but perhaps this is to follow after they have grasped the title of M.D.

Again, the degree of any University worthy of the name implies that the holder of that degree has had a good general education. Can it be said that the diploma of the College carries with it this implication, when the examination of the College of Preceptors is one of the entrance examinations?

When it is said in "Passim" that the "handicap" of the diplomate is felt "in after years," reference must surely be made to practitioners; and yet later it is said "in practice the handicap may not be severe." So far as practice is concerned, the qualification of M.D. makes very little difference. I know several men without degrees who have larger practices than the graduates in competition with them. Success in practice does not depend upon qualifications. The public judge a man by his work and by his character, and I would suggest that the practitioners who are dissatisfied with their present state should look for the cause of their failure in their work or in themselves rather than in their qualifications. So far as Hospital appointments are concerned, surely the proper course for diplomates to take is to get the diploma recognised as a sufficient qualification for a Hospital post, and not to ask that they shall be given a title to which they have no claim.—Yours truly,

"EQUITY."

Testimonial to Miss N. Strick.

Dear Sir,—I should consider it a great favour if you would insert the enclosed letter from Miss Strick, late Sister Clinical, in the next issue of the Gazette. For the benefit of those "Clinicals" who were unable to see the present, I should like to state that it took the form of a set of three pierced Silver Rose Bowls, with burnished copper linings, mounted on an ebonised plinth.—Yours truly, J. SEPHTON COOPER.

May 14th, 1908.

Dear Mr. Cooper,—I really do not know what I can say to express what I feel; but will you please thank all those who have given me that beautiful present, and tell them how much I appreciate their kind thought, and how greatly I shall value it.—Yours very sincerely,

May 12th, 1908. N. STRICK.

Guy's Hospital Musical Society.

The second concert of the thirteenth season of the above society took place on Tuesday, May 12th, in the Court Room, at eight o'clock. There was a large and interested attendance. The programme was arranged in two sections, the first part consisting of vocal music in the hands of Mr. Henry Taylor, while the second was entirely instrumental under the direction of Mr. Herbert Eason.

The vocal portion of the programme consisted of but three items, preceded by Costa's arrangement of the National Anthem, which was very well rendered. The first of the three divisions of the programme was Prout's "Freedom," a song of national character describing the unfettered liberty of the English man and woman, a heritage from our Celtic and Teutonic forefathers, and strengthened and sweetened by the blending of two so widely different constituents. The song begins with a baritone solo, very well sung by Mr. P. S. Price. Then follows a four-part chorus, after which come successively three solo parts by the combined tenors, basses, and sopranos and altos, representing the Celtic, Teutonic and Feminine element respectively. Finally a chorus, containing, of course, a fugal portion immediately preceding the last verse, which is a magnificent finale.

Next on the programme was a four-part song for chorus, entitled "Spring's Message," by Niels W. Gade. It has many lovely passages for the sopranos and altos, and is a beautiful piece of work. It was received with much applause.

The final item of this part consisted of a patriotic song, "The Flag of England," written by Rudyard Kipling, and composed by Sir J. F. Bridge. It is a description of the power of the flag given by the four winds in succession, and is a most impressive piece of work. The main part of the song is choral, but a soprano solo was very sweetly rendered by Nurse Mather, who is possessed of a most melodious, but not very powerful, voice.

Mr. Henry Taylor conducted with his usual skill. The pianoforte accompaniment was most admirably rendered by Sister Ethel, who may be congratulated on her excellent achievement of a difficult and tiring task. The organ accompaniment was played by Mr. F. G. Cole, A.R.C.O., who was somewhat severely handicapped by the non-adaptation of the pitch of his instrument to that of the piano.

The instrumental part of the programme followed after a short interval. The first item was Mozart's Serenade in G for string orchestra, very cleverly interpreted. Following this came two violin solos by Mr. Hector Loos, who showed both great skill in technique and thorough acquaintance with the spirit of his subjects. He played two dances by Leclair, "Sarabande" and "Tambourin," and was loudly applauded and compelled to return and play again.

Next came Schubert's "Moment Musical," with its quaint and happy humour, which was demanded twice, and Beethoven's "Turkish March," which was received with enthusiasm.

The final work of the evening was quite the best, Bach's Concerto for Pianoforte and String Orchestra. The pianoforte was undertaken by Nurse Bingham, who undoubtedly scored the success of the evening. Her performance, which must have been the outcome of careful study, was most admirable, and, aided as she was by the orchestral accompaniment, she produced an effect which will long be remembered.

Mr. H. L. Eason, who was at the head of affairs during this section, has added another to his list of musical successes, and the orchestra, as a whole, deserve every praise for a most intelligent and painstaking performance. M. E. B.

A Short Way with Quacks.

THE forbearance of our laws towards the quack and his quackery is a disgrace to the legislature. It is a wonder that all the burglars, housebreakers, pick-pockets, area-sneaks, and others in the descending scale of the thieving fraternity, from Lands End to John-o'-Groats, do not rise up in arms against this preferential treatment; and it is a still greater mystery that the inhabitants of Cavendish Square and its neighbourhood do not pay a visit *en bloc* to No. 20, where Mr. Asquith resides, and, profiting by the frustrated intentions of the suffragists, meet him as he is returning to his room from his morning bath, and wring from him, under these conditions, when he is not likely to be argumentative, a holy vow that he will introduce a Bill to put down the quack at the earliest possible moment. Lesser evils have been righted by sterner methods. So long as the question is treated with apathy by the medical profession, so long will the quack fatten at its expense.

The quack should be as rigorously suppressed as the veriest felon. To allow anyone, without inquiring if he have even a rudimentary knowledge of the ills of the flesh, to hold himself out to cure them for profit, is a legislative countenancing of fraud and charlatanism of the worst character.

Excepting the few who are the black sheep of the faculty—the pariahs, those who have been cast out of an honourable profession for conduct, if not criminal, unbecoming a member thereof—excepting these, the quack is one whose ignorance is only equalled by his impudence; and his right to follow in the steps of Galen is as the right of a thief to tread in the footprints of an honest man, or a *fille de joie* in the path of a vestal. The man who butts one in the waistcoat and steals one's watch is a thief, and does not affect to be anything else; the very act of butting one in the waistcoat and stealing one's watch is a frank, ingenuous avowal of his calling. It is only under the great provocation of finding himself in the dock that he spoils his manhood and plays the hypocrite.

But the quack is ever a dissembler. His effrontery astounds as it disgusts. Those of us, and I trust they are few, who make it a duty to read the self-styled religious newspapers, will find therein his advertisements in all their extravagant verbosity (I have looked in vain for them in *The Winning Post* and *The Pink'un*; perhaps, however, the advertisement managers of these artless journals have never been tempted).

But the quack has been tolerated, if not encouraged; he has, in fact, a *locus standi*; and to deprive him of his living at the stroke of the pen might be deemed, in the circumstances, Draconic and harsh. This could be prevented. My short way with him would be to take him at his own valuation. The quack, we are aware, assumes a knowledge Esculapian. His "degrees" and "diplomas," which he tags to his name, like sunflowers and hollyhocks, look very well at a distance; it is not until you get close up to them that their glory vanishes. Nothing so takes the shine out of the M.D. degree as a wee little Mo' or Mass., placed after it. No matter. I would acknowledge his omniscience and ask him, by way of giving the lie to the aspersions which from time to time are cast upon his capabilities by jealous members of the medical profession, to take the L.R.C.P. and M.R.C.S. degrees, just as a matter of form. Having regard to, and out of respect for, his omniscience, I should fix the date for his taking the examinations within five days of the public announcement of the Act of Parliament dealing therewith. Of course he should pay the proper fees, but I should not require him to do anything so derogatory of his reputation as to walk a hospital. He should be spared this indignity by paying a round sum to be fixed by the Act.

This is my short way with the quack. Anything more eminently just and reasonable to the profession, and poetically retributive to himself, none could devise.

Until then, one must expect him to thrive and his victims to die. Whether the demise of his victims can be regarded as a great loss to the community is a question. I have always suspected the man who seeks the advice of a quack to be without any brains. But my medical friends say I am wrong; that he has

brains, and that it has sometimes been their unpleasant duty, after he has been passed on to them with the death gurgle in his throat, so that they might get all the kudos for it, to examine them on the dissecting table. Allowing him brains, then, I can only suppose they approximate to the cerebrum of his brother on Blackheath and Peckham Rye, the *asinus vulgaris*.

R. C. A.

Dental News.

Our congratulations, and best wishes for their future careers, to those men who have just completed the Final L.D.S. In Part II., seventeen out of twenty men completed the examination, an excellent result. The pass list in the First Professional Examination was also good.

It is rumoured that several men who ought to have passed in Metallurgy did not, as they left the reading of an easy subject too late. This is an old story; but it seems a pity that men do not take this subject more seriously; the practical course at the hospital is made interesting and instructive, and the subject is one of the most really practical and useful in the whole curriculum.

All good wishes to those who have entered this session. They are joining a Hospital with great traditions, with a great record for hard work and good sport, and we hope the Freshmen will do their share of each with all the energy at their command.

The Dental Society, in common with other hospital societies, does not meet during the summer term, except for the Annual General Meeting, when the result of the Society's Prizes are announced. The date of this meeting will shortly be announced, and it is hoped all the men will come.

Congratulations are due to Mr. Harold Harrison who has been awarded the Entrance Exhibition in Dental Mechanics.

Attention of Freshmen playing Golf is drawn to the Guy's Golf Club. It is being arranged for men to play on special terms at Chingford during the present year. We hope that all golfing men will go down to Chingford. Mr. Gibbons is the Dental representative on the committee, and will be pleased to give any information to intending players.

After the question on Opsonins in the recent L.D.S. paper, men were endeavouring to improve their knowledge of the matter; the May number of the *Practitioner* is especially devoted to this subject.

In the *Dental Record* is Dr. Harold Sims' paper on Pyorrhœa Alveolaris, read before a recent meeting of the Odontological Society. The work for this paper was done by Dr. Sims in the Bacteriological Laboratory when he was a student here.

In Lighter Vein.

RAIN.

I find it irksome to be gay;
Where'er I look, this world of pain
Is one dank steamy plethora,
And still the persevering rain
Drips briskly on the sodden marl
Moist as a consonating râle.

So sit, old sport, with me to-night,
And in that sitting-room of mine
We'll pull the pallid curtains tight
And pile the puling fire with pine;
And you shall choose the livelong night
'Twixt crême de menthe and Black and White.

Pick through my books and magazines
Which make by now a lengthy ridge,
Or if you want more ancient scenes
We'll try to raise a four at Bridge,
Or I'll oblige if you confess
A partiality for chess.

But if, alas! you cannot come,
And I must spend to-night alone,
And if I find, depressed and glum,
That all my drinkables have flown;
If by my uninviting bed
There's not a book I haven't read—

If myriad patience-games refuse
To interest me, if I fail
To cultivate my humble Muse;
If no amusement can prevail
To dissipate the general murk—
Well, hang it all! I'll do some work.

S. S.

Papers by Guy's Men.

The Comparative Anatomy, Gross and Minute, of the Thyroid and Parathyroid Glands in Mammals and Birds. Part II. By David Forsyth, M.D. Lond., M.R.C.P. Lond.—*Journal of Anatomy and Physiology*, April, 1908.

The Goulstonian Lectures on the Influence of Pregnancy upon Certain Medical Diseases, and of Certain Medical Diseases upon Pregnancy. By Herbert French, M.A., M.D. Oxon., F.R.C.P. Lond. Lectures I. and II. —*The Lancet*, 2nd and 9th May, 1908.

On the Diagnosis of Medical Diseases of the Joints. By W. Hale White, M.D. Lond., F.R.C.P. Lond.—*The Clinical Journal*, 6th May, 1908.

Odds and Ends of Interest.*

Fig. 1.—Calcareous Mass in the Brain.

The first, as a photograph, is the least satisfactory. It represents a portion of a brain, but unfortunately does not show as clearly as it might do the feature of interest. There is a calcareous mass visible on the surface, the situation of which is marked by a black line. Another large calcareous mass was present at the apex of the right lung, and since no evidence pointing to syphilis could be discovered in any of the organs at the time of the autopsy, there is good reason to suppose these masses were tuberculous. The specimen was removed from a woman æt. 43, who died after amputation for a compound fracture of the leg. The husband was written to after the calcareous mass had been found in the brain, and he replied, saying, that thirteen years before she had suffered from headache for some weeks, but so far as he remembered there was no vomiting. He stated that he had never had any venereal disease, and it may be added she was said, at the time of death, to have four healthy children living. Two had died, and there had been one miscarriage. It has not been intended to comment upon these photographs, yet it may not be out of place to mention that although text-books do not always mention the fact (one text-book, for example, states "it is necessary in all cases to give an absolutely unfavourable prognosis"), tuberculous cerebral tumours may become quiescent. Williamson, Casar, Fagge, and others, have recorded cases in which calcareous tuberculous tumours of the brain have been found in the post-mortem room, and Dr. Frederick Taylor mentions a case, considered to be an example of this disease, which recovered. Possibly it should be mentioned that without a post-mortem examination it is difficult to be absolutely certain that in a case presenting symptoms of cerebral tumour such a tumour is present. Acquired hydrocephalus in a child may sometimes simulate a cerebral tumour. An example of this occurred when I was clerk in the clinical wards at Guy's. A boy, thought by all who had seen him to be affected with cerebral tumour, proved, after death, to have been suffering from acquired hydrocephalus.

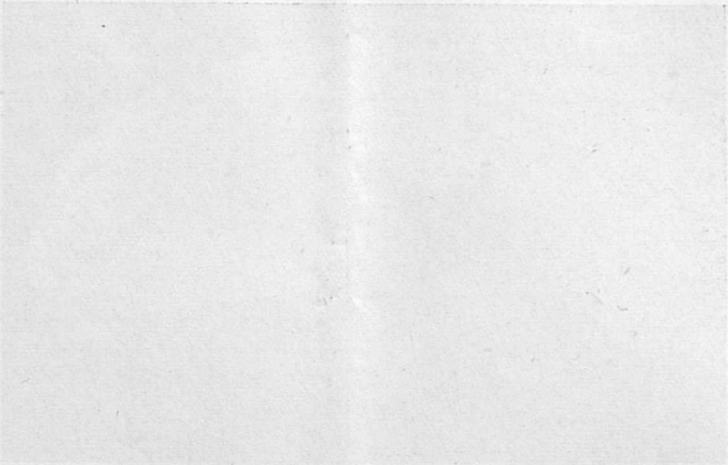
* *Nearly everyone possibly has notes, or it may be some photographs and sketches, illustrating features of medical or surgical cases which at one time seemed to be of interest. The notes or sketches lie safely stored it may be for years, and when looked at again the interest seems in great measure to have departed. Yet although records of cases which have previously passsed under observation may not later stimulate us sufficiently to take the trouble to present them in some form we should consider suitable for publication, possibly we may be wrong to let them lie hidden because of deficient energy on our part, or by reason of want of opportunity to deal with them satisfactorily. Acting under the belief that illustrations may frequently convey knowledge, although unaccompanied by explanatory comment, I venture to send the following photographs, and trust that they will encourage any Guy's men—and there must be many—who have in their possession notes of interesting cases to send them along.*

Fig. 2.—Hypertrophy of Muscular Tissue associated with Malignant Growth.

The second photograph shows a section through a scirrhus carcinoma of the pylorus, and above it a portion of the diaphragm thickened by secondary sarcomatous growth. I photographed these two specimens together in order to show the effect of both carcinomatous and sarcomatous growth in producing hypertrophy of involuntary muscular tissue. Fully half the thickening seen in carcinoma of the pylorus is nearly always due to hypertrophy of muscular tissue. Similar hypertrophy may be seen in carcinoma of the intestine or in the vagina when growth extends from the cervix to the vaginal wall, but is not in these situations as a rule so marked as in the pylorus. The growth which occasioned hypertrophy of the muscle in the diaphragm was lympho-sarcoma, secondary to lympho-sarcoma of the ileum, in a boy æt. 10.

Fig. 3.—Thrombosis of the Pulmonary Artery.

The third photograph shows a thrombus in the left branch of the pulmonary artery. It occurred in a girl, æt. 13, in whom much subcutaneous œdema was present associated with large white kidneys. Extensive throm-



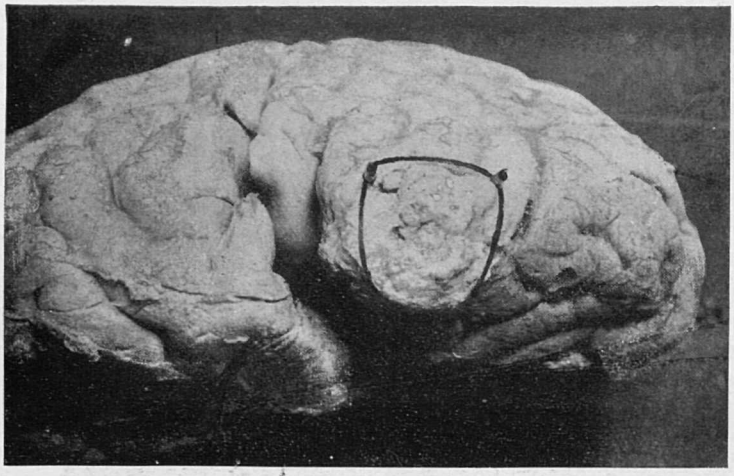


Fig. 1.—Calcareous mass, probably quiescent tuberculous tumour, in the brain.

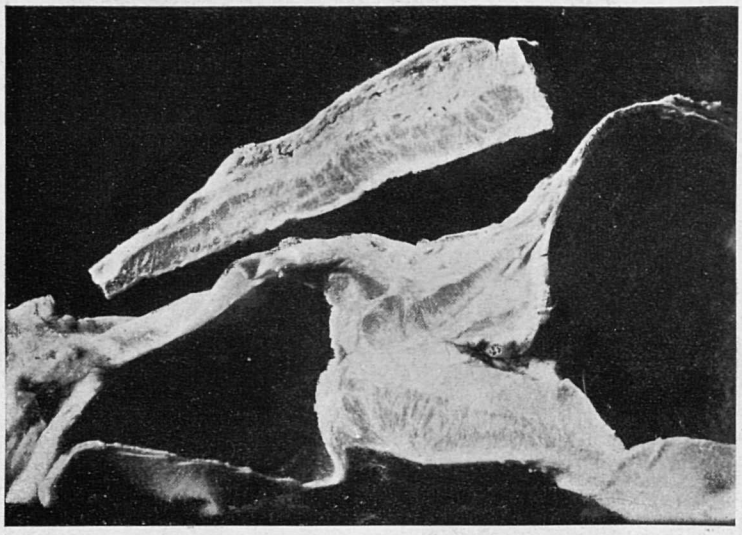


Fig. 2.—Carcinoma of the pylorus and secondary sarcoma of the diaphragm (the upper portion), showing hypertrophy of muscular tissue.

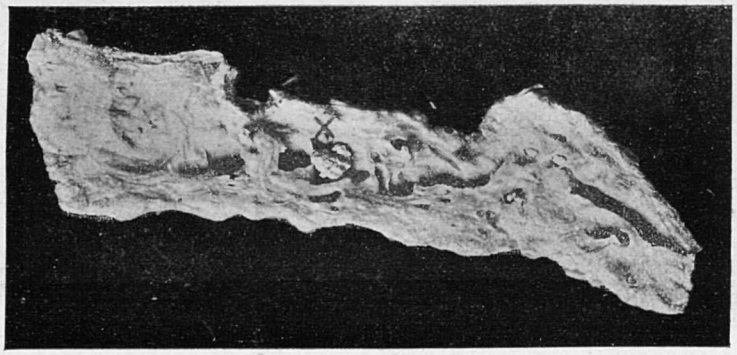


Fig. 4.—Pancreatic calculus. X marks the position of the calculus

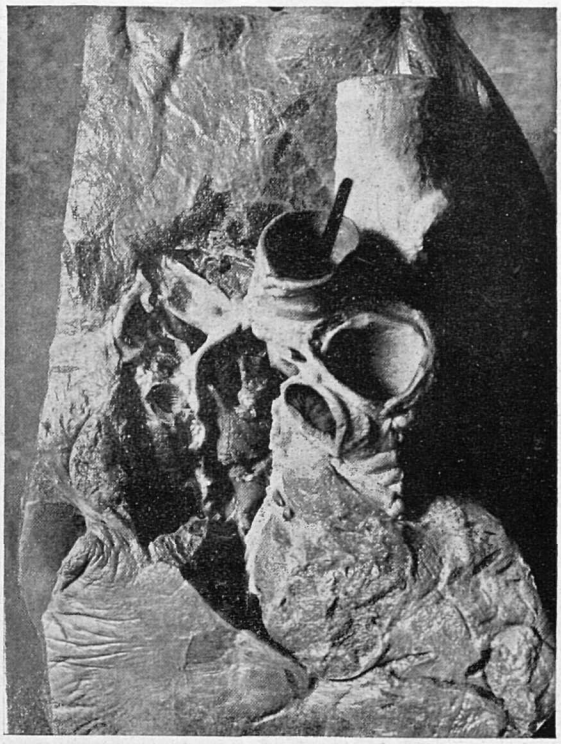


FIG. 3.—Thrombosis of a branch of the pulmonary artery.

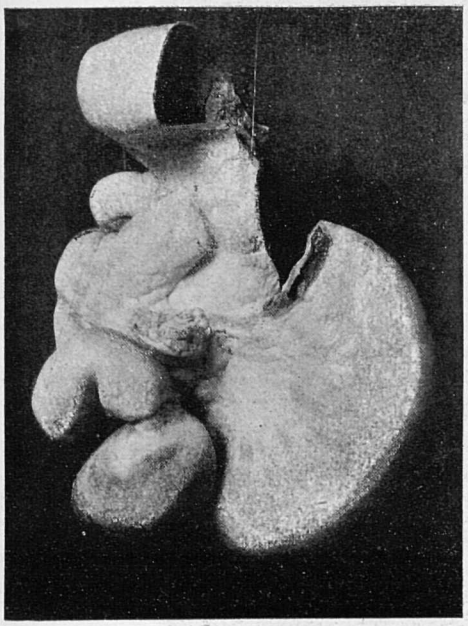


FIG. 5.—Stricture of the ileum in chronic peritonitis.

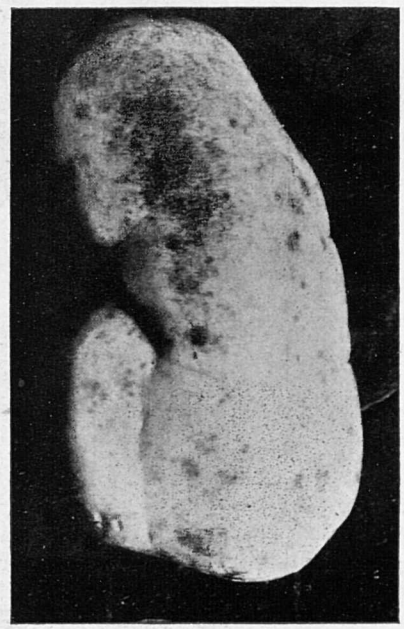
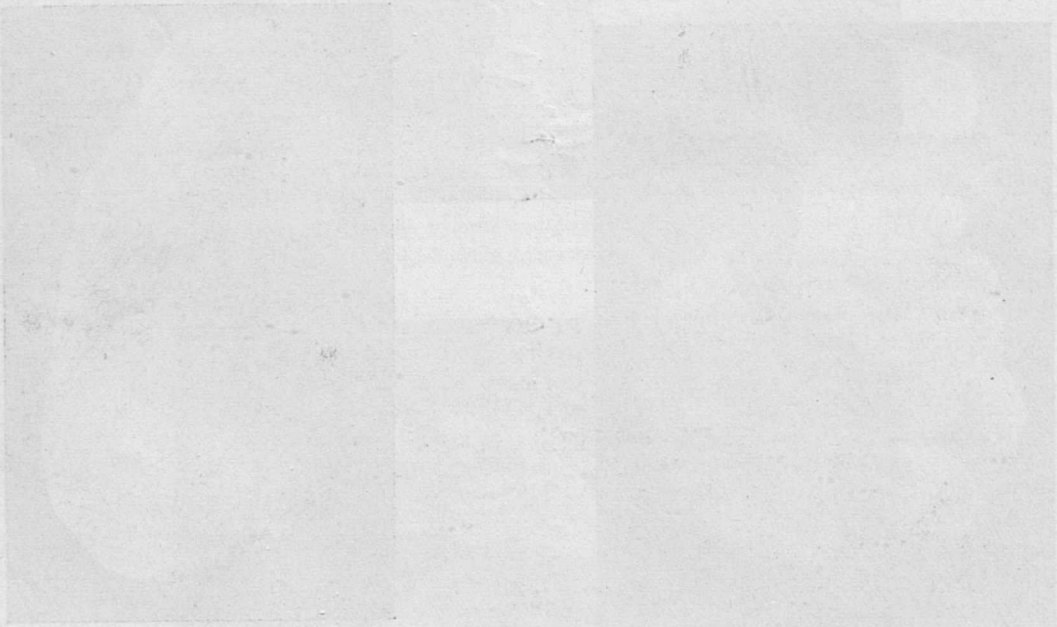


FIG. 6.—Kidney of a child in death from purpura.

of Interest.



bosis in the main branches of the pulmonary artery is rare, but the presence of pale thrombus in the smaller divisions of the artery may now and again be seen. When thrombosis of these small vessels is present, they stand out on the cut surface of the lung; distended and firm they are rendered prominent by the elastic lung substance retracting away from them. I have seen this thrombosis on two occasions in association with chronic peritonitis with effusion, and other examples have been met with where septic infection has been present. On one occasion I suspected its presence correctly during life. A surgeon, a day or two after removing an ovarian cyst, asked me to see the patient, who had been seized with dyspnœa. A systolic murmur, widely heard, was audible over the upper part of the chest, which had been thought to indicate aortic stenosis. The murmur seemed to me to be louder over the pulmonary than the aortic area, and believing, as I do, that such a murmur is frequently produced by dilatation of the right side of the heart, I suggested that the murmur possibly indicated such dilatation following thrombosis of divisions of the pulmonary artery. The post-mortem examination on the following day proved my suggestion to have been correct. All the valves of the heart were perfectly healthy, and the cut surfaces of both lungs were studded with thrombosed divisions of the pulmonary artery.

Fig. 4.—Pancreatic Calculus.

The next photograph possibly does not very clearly indicate the morbid condition present. The letter X marks the site of a pancreatic calculus. The calculus, which has a granular almost spiculated surface, is situated in an atrophied pancreas which was removed from a man æt. 60, who died of diabetes. Numerous cavities are seen in the substance of the pancreas, and these, when the gland was first cut into, were filled with calculi. The remainder of the calculi were unfortunately thrown away by a careless museum assistant. Pancreatic calculi appear to be of two varieties, granular, of irregular shape and numerous, like those present in this specimen, or solitary, ovoid and smooth. When solitary and smooth, they are generally situated in the duct of Wirsung, and may give rise to severe colic.

Fig. 5.—Stricture of the Ileum in Chronic Peritonitis.

This photograph illustrates stricture of the ileum, due to contraction of the thickened peritoneum in chronic peritonitis. The narrowed portion of intestine was situated one foot above the ileo-cæcal valve. It occurred in a woman æt. 41, in whom there had been vomiting for three weeks, and fæcal vomiting for three days before death. The peritoneum showed most noteworthy thickening over the constricted portion of the ileum, it was everywhere opaque, and had lost its normal lustre. The liver was healthy, but a chronic ulcer was present in the stomach.

Fig. 6.—Large White Kidney in Purpura.

The last photograph is taken from the kidney of a girl, æt. 4 years, who died of purpura of a few weeks' duration. There had not only been a purpuric rash, but hæmorrhages from the nose and intestine. The kidneys are much enlarged and pale, examples of the large white kidney. The enlargement was due almost entirely to interstitial changes. As is usually the case, where there are large white kidneys due to interstitial changes, no subcutaneous œdema was present. Nephritis has been noticed to occur in purpura in children, which is not surprising, since purpura is frequently of infective origin. Another disease due to micro-organisms of septic nature in which similar nephritis may occur, is infective endocarditis. Here the kidneys, when markedly affected, are pale and enlarged owing to interstitial changes. Hæmaturia, when present in infective endocarditis, it may be remarked, is almost invariably due to this nephritis, not to infarcts, as is often stated. Infarcts lead to very trifling and transitory hæmaturia.

It should be stated that the above specimens are in the Museum of the Bristol Royal Infirmary.

THEODORE FISHER.

Notes of a Roving Guy's Man.*

III.

Closely connected with intra-thoracic methods of œsophagectomy is the recent work that has been done in the field of lung surgery, and here, too, German surgeons have been well to the fore, the pioneering studies of Gluck in particular, Mikulicz, Rehn and Goldman having shown what surgery is able to do for lung lesions which have hitherto been left to the tender mercies of the expectant physician. Not that surgical interference in cases of pulmonary lesions is a modern innovation. Hippocrates, who appears to have foreseen most things (even aseptic surgery), operated for empyema by resecting a rib, an operation which Herophilus had already suggested, and which remained in vogue until Galen, fired with the physician's enthusiasm to puncture things, evolved an aspiration syringe, which must have had as many victims as Madame Guillotine. Through Galen's persistent opposition, resection of the rib and pleuracotomy fell into disuse, to be resurrected as late as 1859 by Roser. No one paid any attention, and the operation was again suggested by Simon in 1869, and was performed a few years afterwards by Mosler. Abscesses of the lung were opened by Schenk in 1589, by Baglivi in 1696, and by Sharp in 1769. Since 1873, when pleuracotomy came into favour, lung operations, mostly for abscesses and empyemata, were often performed, but the foundations of most of the modern methods were laid in 1882, when Gluck described his resection of a part of the lung. He was followed by Murphy, by Tuffier and Doyen, of Paris, who resected tuberculous apices and opened up vomicæ, and he has himself energetically worked at the subject, changing and modifiying his methods. The original resection method was to open the pleural cavity, to herniate a portion of the lung, and to wait for adhesions to form around the herniated portion until it could be removed by means of the thermo-cautery. The results obtained by this method were excellent. Thus, in March, 1899, Professor Gluck operated on a patient with purulent bronchiectasis of the left lower lobe. Four ribs were resected subperiosteally, and the whole of the left lower lobe, riddled with large cavities, was successfully resected. The patient, by no means a perfect subject, made a splendid recovery, but died suddenly from heart trouble at the end of the same year. A year before, in Helferich's clinic, a similar large resection, also of the left lower lobe, was done for sarcoma, but the patient died twenty-four hours after the operation. Recently Gluck has operated on several interesting cases with very encouraging results. Two cases are especially remarkable, as in both almost the whole of a lobe was extirpated for chondro-sarcoma, the patients recovering perfectly. As the Professor remarks, these cases have shown the truth of the three surgical maxims which should, above all things guide the modern practitioner—"Ubi pus—ibi incisio: ubi hæmorrhagica—ibi ligatura: ubi tumor—ibi extirpatio." The latest modifications concern, of course, the methods of operating in such lung cases in specially constructed chambers. There is as yet no definite decision as to which type of chamber is best. At Breslau they have a modified "low-pressure" Sauerbruch's cabinet, which was specially constructed by Professor Mikulicz: at the Virchow they also have a low-pressure apparatus: at Hamburg and elsewhere they favour the high-pressure cabinet, but the results are as yet insufficient to enable one to compare the merits of the two conditions. The Sauerbruch cabinet is quite simple, though it is very expensive to construct. It consists of a double casing, an inner chamber for the operator, assistant and patient, and an outer one for the æsthetist. At Breslau they have quite a large armamentarium of specially constructed instruments for use in this method of operating, but they all seem to be superfluous refinements, and at Heidelberg the ordinary instruments are made to serve equally well. The Brauer cabinet is a much smaller affair, and differs from Sauerbruch's in that the atmospheric pressure is positive instead of negative: it is said to be less effective than the original negative pressure apparatus. Dr. Robinson, in a recent number of the *Annals of Surgery*, and the pupils of Mikulicz, in that most excellent Festschrift to the memory of the Master which has just been published, gave a series of results, obtained by experimenting on animals, to show the relative merits of the two kinds of pressure. To a large extent, however, the collapse of the lung, which is so dangerous in these operations, is due not so much to air pressure as to the contractibility of the lung tissue, and the main dangers of resection of the lung, as of posterior œsophagectomy—dangers such as excessive loss of temperature, irritation of the vagi endings, failing heart and shock—cannot be prevented by using either cabinet.

A very interesting observation has recently been made by Professor Gluck. He found, in one of his cases, that a boy who had a bronchial fistula was able to breathe quite easily with his mouth and nostrils closed. In his lung resections the Professor confirmed this observation, and he proposes now to call this type of breathing "retrograde respiration," and suggests that, in cases where tracheotomy is impossible or useless, posterior bronchotomy may save the patient. The operation is performed as follows: the patient is turned on his side, and a ∪-formed incision, with its base external, is made into the tissues lying over the fifth to eighth rib. These ribs are resected subperiosteally, and the bronchus is at once reached, lying approximately 7 cm. from the surface. The point where it is struck, if the operation is carefully made, is invariably easy of access, and the finger can be passed along it up to a centimetre from the bifurcation. The operation is extra-pleural, and intra-pleural bronchotomy is only advised in very rare cases. The bronchus is opened by a longitudinal incision, and a tube is inserted into it, through which the patient breathes easily and freely.

* Series I. and II. of Notes appeared in GAZETTE of April 4th and May 2nd.

One of the points in which the surgical student is interested is the treatment of cases of peritonitis. It is a condition which any one of us may be called upon to treat actively, and it is, unfortunately, one upon the question of the treatment of which no two methods or no two opinions agree. No one watching our own methods, and considering our own mortality figures, can regard either as satisfactory. Counter-incisions, large drainage tubes, prolonged messing about with swabs and gauze rolls in the abdominal cavity, such as every clinical is familiar with, hardly seem good surgery. They suggest much more the "mutilation methods" which, Larrey said, disgraced the surgery of France in his day. Apart from the risks of ventral hernia (a risk which, I admit, is relatively small, as these patients rarely have a chance of developing any surgical lesion after such an operation), the shock to the patient must be much greater than with gentler treatment. It has always appeared remarkable to me that those who strongly object to gentle peritoneal lavage in such cases, have apparently no hesitation whatever in subjecting the abdominal contents to a scrubbing and dry brushing which would make the average charwoman stare, and to look with great favour upon side incisions, in the happy expectation that these will secure a better drainage. We, at Guy's, are not singular in these methods of abdominal laundry work, and I have seen, here and elsewhere (at Lille and Zurich, for instance), an even more horrible method of dealing with cases of diffuse general peritonitis. I do not know what our mortality is, but I should be surprised to find that it is less than 60 per cent (in Clinical, at least). Figures here vary very much, for the methods vary widely, but as an average, 45 per cent. is probably very near the mark, with the single exception of the large surgical clinic at Eppendorf, near Hamburg. There, under Professor Kummel, cases of diffuse general peritonitis are treated in a manner which seems rational, and which has been crowned with the most brilliant success. Much as I admired the method, I was scarcely prepared to hear that it has reduced their mortality from 40 per cent. to 9 per cent.—and they are certainly not dealing with cases less severe or less fatal than other hospitals.

The Eppendorf method is to open the abdomen by a median longitudinal incision (the transverse incision has not yielded good results here), and to find, if possible, the source of the peritonitis. If this is the appendix, the remnant of it is removed by simple ligature. The abdominal cavity is then flushed with normal saline, great care being taken to prevent any eventration, but the operator passes his hand into the peritoneal cavity and separates adhesions, especially low down. Comparatively a small amount of saline is used to flush, and no attempt whatever is made to mop up the fluid or to get it out. The abdominal wound is then sewn up quickly, the lowest corner being left unsutured to allow the passage of a long Dreesman's glass drain, of the calibre of the index finger. Into this a long strip of vioform gauze is passed, soaked in normal saline. The patient is put back to bed after the operation (which is done very quickly) in a very moderate Fowler position. Saline per rectum and camphor injections are given. The gauze drain is changed every eighteen hours; the glass drain on the fourth day, when it is replaced by a smaller one. The wound itself is packed round lightly with vioform gauze. The Dreesman's drain, with its gauze tampon, acts most efficiently; the gauze does not stick, but appears to drain well, and, as the statistics show, the results have been excellent. Great stress is laid upon operating quickly: the simple ligature of the appendix hardly adds to the length of the operation. Camphor injections are freely given, strychnine only when there is distension or intestinal atony.

Another interesting feature of German abdominal surgery is the tendency to operate more frequently in cases of acute cholecystitis—a disease which has so far been left very much to the medical colleagues. Why appendicitis should be worth the surgeon's attention and cholecystitis be left to the physician to treat empirically is a mystery, but the tendency now seems to be to become rational, and to advise surgical interference in all cases. The only question now is, when and how; and one still hears long discussions on the value of jaundice as a sign for interference, though I believe it is universally admitted that jaundice is not an objective symptom in uncomplicated cases of cholecystitis, and therefore those who make it an indication for surgical interference practically limit such interference to complicated cases where the condition is no longer confined to the gall-bladder, but has reached wider limits—virtually either a cholangitis or a peritonitis. On the question of when to operate there appears still to be a vast discrepancy of opinion. At Breslau they say, "as soon as you like"; at Heidelberg, Narath simply follows his old master Czerny, and lays down the principle that no simple cholecystitis ought to be operated upon in the acute stage. Narath's rule is briefly this: Let the physician treat the patient; he can't do much harm so long as you see he does not administer calomel or a purgative. Treat the patient medically with cold or hot flannel applications, water diet and complete rest, and watch him carefully. Your indication for interference during the acute stage is when the "disease threatens the life of the patient"—a dictum which reminds one of Paracelsus' reply to the Galenist. "When," queried the Galenist, "oh worthless charlatan, ought the leech to phlebotomise a moonstruck?" "Then only," quoth the gentleman who re-introduced opium into medical practice, "when it is necessary to open the turgid veins!" When does cholecystitis threaten the life of the patient? When it is no longer cholecystitis, but peritonitis? Then everyone is agreed surgery holds out the only chance, but how far does a similar rule of *non-interference hold in cases of appendicitis?* The Heidelberg school, of course, is consistent. They do not operate on cases of acute or complicated appendicitis. They treat these medicinally, and remove the appendix during the quiescent stage, and they recommend a similar course of treatment in cases of chole-

cystitis. It is, however, an advance to insist upon the advisability of operation even then, and a decided gain to surgery to have established a claim upon such patients. The other question is what operation to do, and here there is less difference of opinion, the majority favouring cholecystectomy. Why a surgeon should do a cholecystostomy in such cases and an appendicectomy in cases of appendicitis is as much a mystery as why he should have so long neglected cholecystitis, and yet there are many surgeons who favour the simple operation of draining the gall-bladder instead of the radical and less fatal* one of totally removing it. Doubtless the latter may take more time and demand more precision and greater expertness on the part of the operator, and for that reason cholecystostomy may be the ideal operation for the timid or inexperienced practitioner. But this class of person does not usually operate on cases of cholecystitis, and it is a little difficult to see why cholecystectomy is not more favourably regarded by many hospital surgeons who have at hand all the best appliances and the best assistance to smooth over the difficulties in operating on acute cases. The systematic publication of results, good and bad, obtained by such operative treatment will bring the whole subject prominently before the profession. This, I am told, is to be done here. The statistics and records of operations in cases of cholecystitis are to be collated and published at the end of the year, and the publication ought certainly to be as useful as it will be interesting.

Regarded generally, the abdominal surgery I have seen here is not marked by so high a general standard of excellence as one sees, for instance, at Paris. Incisions are always conservative—that is to say, small—and are usually transverse. Quickness, more perhaps than neatness, is a feature, not because the books say so, but because rapidity of operating has certainly tended to diminish the number of deaths from shock. The deliberate leisurely way of opening the abdomen and doing an entorrhaphy, such as one sees at Milan, is quite unknown. Under lumbar anæsthesia the operator must finish within the hour, and under chloroform it is recognized that quickness is at any rate desirable. The fall in temperature after the evacuation of an appendicular abscess is often as much due to the large dose of chloroform the patient has received as to the evacuation of the pus, and certainly here the temperature charts are more even than with us. Not that anæsthetics are well administered. In the larger operations apparatus, modifications of the Vernon Harcourt type of inhaler are used; at the smaller, the Eppendorf cone with two valves. The first time I used the latter, at Professor Klapp's clinic, I had the utmost difficulty in keeping the patient under, and discarded the cone for the Simpson method, to the great amusement of those present. Since then, however, I have used the cone on several occasions, and have become more familiar with it, though I am afraid I shall never attain to the easy nonchalance with which the anæsthetist here pours the chloroform in at the top! Ether anæsthesia is usually deep, and the patients are often deeply cyanosed. The Junker apparatus I have not seen used: a Schimmelbush's mask serves for most purposes where the Eppendorf cone is not used. The latter is small and very neat and compact, but it is difficult to keep it firmly over the patient's face, and the valves are liable to get out of order.

Appendicectomies are usually done by simple ligature without "plication" or "involution." Sometimes the purse-string suture is used. The gridiron method of incision is not done; the transverse incision serves equally well. Discussing with a friend the comparative merits of the simple ligature and the invagination methods, he directed my attention to a passage in an old manuscript at the Royal Library here, a passage which is so interesting that I make no apology for transcribing it here. The operator was Zambeccarius, a surgeon of the 14th century, and the passage occurs in Morgagni who refers to Zambeccarius: "*Qui cum appendiculæ portionem injecta ligatura batello abscidissit, tribus jam exactis mensibus, et hanc solutam et ilius fundem omnina apertum vidit, neque tamen ullas fæces in ventris caveam ex illo decedisse comperit.*" An equally interesting passage on appendicitis occurs in Fabricius Hildanus, an excellent edition of whose works is in the Royal Library here. It is the whole record of the case of one Cosinus Slotanus, and runs as follows: *Ad honestam matronam accersitus eam invenit decumbentem cum acutissimis doloribus circa lumbos, febre, leipothymia* (what we should call "in a typhoid state") *et urinæ difficultate. Is quum ex doloris specie aliisque indicis cognovisset, apostema esse internum, minirum sub psoa musculo, vitæ periculum prædixit, nisi forte aperto latere illo contentus humor effluret. Annuentibus amicis, ipse ad spina dorsi latus cutim musculos exterioresque ad psoam usque incidit novacula. Effluxit copiosus tumor purulentus fœtidisque.*" The "wide opening," it is satisfactory to note, cured the patient. The two extracts are interesting points in the literature of the surgery of the appendix (for No. 2, I take it, must have concerned appendicular abscess), in comparison with which, in point of priority, the often-quoted aphorisms of Boerhave on Paraphrenitis must take a back seat, while the references to Copeland, Bright, and the first modern describer of appendicitis, Lourger Villermays, of 1824, must appear quite juvenile. Zambeccarius' case may be adduced in favour of the ligature, and Hildanus' in favour of the Eppendorf treatment of diffuse peritonitis!

There is one new feature in abdominal surgery here which it is worth while noting. I refer to the magnesium button for entorrhaphies which Schlumfpsky, of Cracow, has perfected. The ordinary Murphy button has, as

* I am aware that it is stated that cholecystostomy is a simpler and less fatal operation than cholecystectomy. The statement is, I believe, repeated in the new edition of Mr. Jacobson's well-known "Operations of Surgery," where Mayo's statistics are adduced in its favour. I have not the edition by me, and so cannot look it up. The statistics of Goldmann, of Freiburg, of Courvoissier, and those recently published of Arnsperger, however, clearly show that the radical operation is attended with a relatively lower mortality. In France, Forguet and Reclus' statistics, though old, tend to show the same thing. Mr. Bland Sutton's recent work does not lay stress on this presumed fatality of cholecystectomy.

every surgeon knows, several disadvantages, and several objections have been raised to its employment. It is not necessary here to detail these objections.* Suffice it to say that the main points against it are its weight, and the fact that it is non-absorbable. The former failing leads to too early and rapid junction necrosis, with consequent danger to the anastomosis site. If this site has to be strengthened by sutures—a precaution which Murphy himself condemns—the great advantage of the button, its ease of insertion, is lost. The second disadvantage has led to real dangers owing to the button causing obstruction. Too early loosening of the button leads to weakening of the junction line and probably to stenosis of the lumen of the bowel. These disadvantages are, it is said, overcome by making the button of a lighter and absorbable material, and magnesium metal has been found excellent. A magnesium button (which is similar to the Murphy type, except that it is much lighter, lower (flatter), and that it has an additional grip, while the screw is spiral) is said to be gradually absorbed, but such absorption does not take place within a fortnight, thus allowing ample time for the anastomosis to be perfect. The great disadvantage of the magnesium button is its expense, which at present is almost prohibitive, especially as the buttons cannot be used over and over again. Where they have been tried, the buttons have served admirably, and their introduction certainly marks an epoch in general surgery. For German surgeons have not been slow to adapt the advantages of the absorbability of magnesium to other conditions. Thus it is used in the treatment of cavernous angiomata. Slips of magnesium are inserted into the cavernous tissue, under strict aseptic precautions, of course, and the part is bandaged fairly tightly. The magnesium appears to cause a shrinking in the tumour, which gradually becomes smaller. When the wires are no longer to be felt, others are inserted, and the treatment continued until the tumour has practically been cured. Equally good results have been obtained in interpositions for the creation of a pseudo-arthrosis. The best case I know of is one of Prof. Biers. The patient, an officer in the Army, had been wounded in conducting an outpost affair in South-West Africa. The bullet had struck the two bones of the forearm, shattered the olecranon and the internal condyle, and had lodged behind the latter. When invalided home, the patient's forearm was stiffened, the elbow joint destroyed, and the superior radio ulnar joint involved. The result was a complete ankylosis with loss of rotary movements in the forearm. At the operation the sinuses were cleared and the joint very freely resected. Magnesium plates were placed between the bone ends, and the wounds closed, the arm being splinted, though passive movements were begun at a very early date. The result is most excellent. The patient has regained his full power of flexion, extension is a little freer than normal, and he is able to pronate the forearm to a certain extent. It would be highly interesting to see how the method answers in hip cases, where it would appear to be indicated in conditions for the relief of which Mr. Jones has recently done his bone-muscle interposition with such good results.

Berlin is in the proud position of possessing the most up-to-date, and certainly the most expensive hospital in the world, and no medical man coming to the city should lose the opportunity of seeing it. This hospital is the Rudolph Virchow Krankenhaus,* facing the See Strasse, a monster building, which the municipality has erected to the memory of the great German pathologist. I have had an opportunity of going over it, literally from top to bottom, and have since visited it several times, though from a surgical point of view it is less interesting than the majority of clinics. It is built on the pavilion system, and consists of an aggregation of fifty-seven separate buildings, lying in a park that covers twenty-five hectares of ground. Its cost up to date is just under a million, and it provides accommodation for nearly 2,000 patients, while it houses an enormous staff—practically one attendant to every three patients! From an architectural point of view the hospital is magnificent. It reminds one of the Louvre, or of the Ducal Palace at Mannheim, and the fine lines of the "administrative block" are certainly artistically effective. For all that, the hospital is, as it seems to me, a mistake. It is much too large, and involves a much too great expense in upkeep. One needs not a day but a week to go over it, and no matter which department one enters, the impression one gets is that no expense has been spared, but that no outstanding results have been obtained. The enumeration of what appears to be the faults of the institution would be of little general interest, but a few may be mentioned in passing. The pavilions (wards) are very large, and each one is, in fact, a small "corridor" hospital, with all the drawbacks that belong to this class of institution: the outlay upon adornments and extras is too great, and the structural conditions in the individual wards are not perfect—narrow windows with multiple panes, a bad arrangement of isolation rooms far away from the sister's room, etc. There is a fine nurses' home, with large lecture, drawing, reading, recreation and dining rooms, and with bed-sitting room suites for the sisters, rooms for the nurses, and dormitories for the 150 probationers. The staff is variously lodged. The heads, who are married men, have their houses or flats; the assistants, one in charge of each pavilion, have rooms in the central block of their respective pavilions, and have a large common room in the pathological block. Every ward and building is in connection with the others by a series of underground galleries, which are specially ventilated. There is a large

* Those interested in the question will find a full description and discussion of the various methods of intestinal suture and prothesis in Professor Schlumfpsky's work which has just been published. The article is a very interesting one, and contains a fairly good historical account of bobbins and buttons, though a few points—such as Abdulcasim's method of anastomosis—the first on record—are omitted. From it one finds that the first button of the Murphy type was made in 1826, and the first invagination method as early as the fifteenth century. The article is well illustrated and is written in such an attractive style that it is a pure pleasure to read it.

* Illustrations were published with Series II.

pathological block, a fine gynæcological building, and special departments for actino-therapeutic, hydrotherapeutic and massage treatment, for genito-urinary and skin diseases, and for infectious diseases. The wards are large and airy, very cosy-looking, with foliage plants and flowers, but with no superfluous extras in the way of lockers, cupboards, etc. Patients are not allowed to have their clothes in the ward, but must wear special dress, and no dressings are kept in the ward. When one wanders about in the grounds, one gets a good general idea of the vast extent of the institution—somewhat similar to the impression one gets at Eppendorf. In fact, in those streets upon streets of pavilions one feels, as Hoyni felt—

"Like a man unholpen in a waste land wending alone,"

only the land is not waste, but a veritable pleasure garden of linden trees and lawn. The hydrotherapeutic department is superbly fitted up, with cold and hot sitting, standing, plunging, and douching and spray baths, with soda, sulphur, Turkish, Russian, "Postyen," and gas medicinal baths. The attached massage department is as complete. The kitchens are the largest hospital kitchens I have seen—surpassing the Hamburg ones—and possess separate sausage, soup, mincing, and mashing rooms. The machinery here, as in the laundry, is driven by electric power, and the building is throughout fitted with a double system of electric lights and telephones. Water is got from several artesian wells on the premises, and the heating is by a double system of gas and steam pipes. The cost of upkeep is as yet difficult to estimate, as the hospital has only been in full swing for about eight months, though it was formally opened at the end of 1906. Through the courtesy of the directorate I was allowed to copy statistics and figures, from which it appears that the daily cost per patient comes to approximately six shillings, which is almost double the figure given for the other municipal hospitals, whose average is 3·5 marks. Taking administrative expenses as well, the cost is approximately 10s. per head per day. The cost of feeding the staff (who have an excellent table) is 3s. per head per day; of feeding the patients and attendants, a general average of 1s. 4d. A few items under expenses were interesting—thus, there was the item £200 for "Christmas and New Year presents to staff," £25 "for financial assistance to discharged patients," and £23 "for instruction to patients."

The surgical side is interesting because of the completeness of its arrangements, for hitherto operative work has not been particularly heavy. During six months 189 operations were done, including the following interesting ones:—Extirpation of tonsils and partial pharyngectomy for sarcoma tonsillæ; removal of glioma of cerebrum; laparotomy for acute volvulus of stomach; Talma-Narath operation for cirrhosis of liver; castration for hæmatocele; forequarter amputation for sarcoma; and hernia of adductors treated by suture of fascia. Several secondary and primary amputations were performed, among others at the knee by the method which appears to be highly favoured here—Djelitzyn's modification of Sjabanejeff's osteoplastic intracondylar amputation. I have seen some results which are really very good. On the dead body the operation is not more difficult than a Carden or Gritti. It consists essentially in sawing off a wedge-shaped slice from the tibia, preserving the tubercle with the attachment of the ligament, and putting this wedge over the sawn end of the femur. The Talma-Narath operation mentioned above is simply a modification of the ordinary Talma-Morrison, which seeks to establish an additional anastomosis between the portal and systemic circulation. A portion of omentum is brought up and "pocketed" between the parietes, the operation being done under local anæsthesia. The operating theatre at the Virchow is really very fine—large, well-lit (during cloudy weather, or when it is necessary to use artificial light, by a series of strong "reflector arcs," placed in ground-glass compartments *outside* the room; the result is a finely diffuse light with practically no shadows, an additional advantage being that no lamps are in the theatre itself) and excellently aired by "natural" methods. It is double, and situated in a special block, built in the centre of the surgical "street," and connected by two long closed corridors, with a male ward on the one, and with a female ward on the other. I was surprised to see these corridors, as I had naturally expected to find the operating block quite isolated, like one of the pavilions, in fact, as is the case at Eppendorf. The present arrangement was the result, as I am told, of a conflict of opinion, the majority of surgeons holding that such covered corridors were necessary—to prevent post operative broncho-pneumonia! At Eppendorf, where patients are carried for long stretches through the open air to and from operations, the mortality from post-operative broncho-pneumonia is 2·4 per cent.; at other hospitals where similar methods prevail it varies from 3 to 4·8 per cent. I have not been able to find out what our own statistics are (St. Thomas's, where the closed corridor exists, is, I believe, 5 per cent.), but I should be very much surprised to learn that they are below the average figure for "closed" theatres, which is 5.9 per cent. Kummel has been at work on the matter lately, comparing the Eppendorf results with those obtained under the "closed" system, and his results are very much in favour of having the theatres quite separate At the Virchow they have a fine armamentarium, which includes a Bauer's positive pressure cabinet. I saw several operations here, but none of them were major ones, and the methods did not differ much from those that obtain elsewhere. The physicians and surgeons are very courteous, and are eager to show their arrangements to the visiting colleague, and they take a pardonable pride in the institution, which is certainly one of the best equipped of modern hospitals. At the head of the surgical section are Professors Hermes and Borchardt, the latter of whom was Excellence von Bergmann's chief assistant at the Royal Surgical Clinic.

Berlin, April. C. L. L.

Reviews, etc.

The price of books submitted for review should in every case be stated.

Confessio Medici. By the Author of "The Young People." (Messrs. Macmillan & Co., Ltd.) 3s. 6d.

Seldom have we enjoyed reading a volume as we have "Confessio Medici." Dearly would we love to know who it is that hides himself under the *nom de plume* of "The Author of the Young People"—which, by the way, we have not read, but assuredly will hasten to. A fund of sympathy, a sense of humour—that happiest of attributes—a scholarly intellect, a power of observation, and an admirable candour, all lie behind the facile pen which has given us a book of a type all too rare. It is a picture of us, our surroundings, and our work drawn by one who is observant in the extreme, one who has had time in the midst of strenuous labours to appreciate the "humanity" side of his work.

In his preface the author apologises for his pilfering of a title on the ground that a poor writer is always tempted by the titles of old books; therefore he has stolen from two. But his "Confessio" means not a confession of sin, for, as he says, "*Not all confession is of sins, and a man may confess his faith, his ignorance, or his love. Use the word as we will, it means no more than this, that he goes outside himself for answer, assurance, audience.*" But, he asks, is it gentlemanly, is it necessary, to thus hurl upon the audience these thoughts which have been his, and his only? Oh! but they tire of their own company, they want to impress, be contradicted, be laughed at, anything to escape the monotony of their own confinement; and even though silence be golden, gold is for circulation, as he naïvely remarks, hence, "*Confessio Medici.*"

Now, of these thoughts: Appropriately enough, he heads his first chapter, Vocation. In this chapter the author's true enthusiasm and love for his profession is manifest on every page. Not one of us after reading it, we venture to say, will feel aught but a thrill of pride at following a life which, if not a "*divine vocation, then no life is a vocation, and nothing is divine.*" He has witty things, sage withal, to say of parents, and a choice of calling for their children. *I mean to be a doctor like father,*" says the pride and joy of the household, and they rejoice over him; "*and a month later he wants to be a fireman or a Member of Parliament.*" And how neatly expressed is his advice to him entering his father's profession, counting on his father's fame or name; as he says, this should be reckoned a liability, not an asset. "*There was Icarus, son of Dædalus, he fashioned for himself wings, to follow his father aloft; and they bore him off the earth, but the wax of them was melted by the sun, and he fell into the sea. . . . They were an accurate copy of the wings of Dædalus; and every young man would like to have wings. And, after all, though Icarus was drowned, yet it was a splendid adventure to fly even a little way; and wax was made to be melted.*"

The second chapter headed "Hospital Life," shows plainly that our author is a "London" man, since he engages in quite a diatribe against tribal worship at other shrines. He is proud of the "*genius loci,*" which still lingers around our great hospitals; he dwells in such a loveable way on the dear old Alma Mater, on the manner in which she unfolds in her kindly embraces men from all parts and every centre of learning, how they, instilled with a love and respect for her motherly charms, are of her and her only. Then he speaks of our work, the reality and grimness, the comic relief and scenic effects of the casualty department, with the great crowd of supers at the back of the stage, the great human kaleidoscope which, under the plea of "sickness," shows itself to the student and teaches him humanity, not in terms of anatomy and physiology, but just humanity.

He contrasts the crowded years of ever-changing hospital work with the dreary dry monotony of the purely bookish curriculum of the law student, and he strikes such a familiar note when he says of the in-patients, "*He likes the off-hand, homely, old-fashioned kindliness of a good hospital; he makes a friend or two, and keeps them. Of us, who entertain him, it may be for a day, it may be for months, he is of opinion that we are a very decent lot, especially Sister.*"

A section headed "An Essay for Students" follows. It is a gem of a chapter; the author talks of psychology. He tilts at it with a lance of good-humoured wit; it is a delightful travesty of the extravagance of the psychologists' ephemeral talk. One sentiment struck us as being very quaintly expressed. Speaking of the impractability of psychology, he remarks, "*What has she to do with our conduct? The influences which determine conduct are not in text-books, but in the home, the school, religion, competition and the policeman; and the application of psychology to individual conduct is like the application of an aseptic dressing to Central Africa.*"

I wonder how many of us have read of Ambrose Paré, the French peasant, who by his intellect and skill rose to great heights. He was the friend and surgeon to the kings of France from Henry II. to Henry III.; he knew Catherine Medici and Mary Stuart; read the chapter called "A good example," and many will want to know more of this chirurgical Boswell, who, by the way, was the pioneer of ligation in amputations.

Of Practice, our author has much to say; he describes her as a "lady, a perfect lady," with a good, sensitive, kind, clever face, absolutely free from the very least hint of vulgarity; but read it for yourselves and realize what sort of a person you will daily have to encounter. In a footnote, he gives his views on the question of hospital abuse, and condemns what all of us know to be unnecessary, the hospital letter system. He says of it: "*Nothing can justify, unless it were the existence of people who would not subscribe even to the maintenance of Heaven, without an Annual Report and the right to recommend four souls for immediate admission if found suitable cases.*"

The book gave us several hours of pure enjoyment, and we are afraid that our ardent admiration has led us into quoting our author rather more than is compatible with a good review; but the setting together of thoughts that many of us at times must have had, and the expressing of many we might have had, gave us the keenest interest imaginable. Then, again, as a record of our work and our daily life, together with succinct remarks on our future life in practice, this volume should be read by all. Undoubtedly the student cast by the writer is perhaps rather an imaginative creature, but, in spite of the rush of an all too short time for a well-filled curriculum, he exists. Author, if "Confessio" is taken as an expression of thoughts so ably committed to paper as these are, give us more!

Transactions of the Royal Society of Medicine (April). Vol. i., No. 6. (Messrs. Longmans, Green & Co.) 7s. 6d. net.

The April number of the Transactions contains many things of interest. In the clinical section Mr. T. H. Kellock tells of an interesting case of hermaphroditism, in which the uterus occupied the sac of an inguinal hernia. Dr. Parkes Weber's case of angina pectoris with aortitis, is interesting in that there can be no doubt as to its being true angina, with no increase in blood pressure. A case reported by Dr. Carruthers of death from cerebral hæmorrhage in purpura hæmorrhagia, shows that though this ending in purpura is a rare one, it may occur.

The dermatological and electro-therapeutical sections are quite as interesting as usual, whilst to the epidemiological section Drs. D. S. Davies and J. Walker Hall contribute an excellent paper on that all-important subject, typhoid-carriers. Mr. F. J. Steward reports a case of mucocele of the frontal sinus, in the laryngological section, and Mr. C. H. Fagge, one of a branchial sinus leading into the external meatus (sinus excised) in the otological section.

Dr. A. Latham, in a preliminary communication on the administration of vaccines by mouth, contributes what must be regarded as a most important paper. The cases he reports on are, in the main, most satisfactory, and his further experiments will be awaited with interest. This paper is one that should be perused by all senior students who are keen on following the modern trend of treatment.

Those who are interested in hypnotism will do well to read Dr. J. Milne Bramwell's paper in the therapeutical section.

The printing and arrangement is maintained at the usual high standard.

Experimental Prophylaxis of Syphilis. By Dr. Paul Maisonneuve. Translated from the French, and with an Introduction by Fernand L. de Verteuil, M.B. (John Wright & Co.) 4s. net.

Ever since the successful inoculation of the anthropoid apes with syphilis by Metchnikoff and Roux in 1903 and Fritz Schaudinn's subsequent isolation of the *Spirochæta pallida*, a new era in the fight against the greatest scourge of the human race has commenced. Daily we wait for the ideal prophylaxis, an anti-syphilitic vaccine, but in the meantime Metchnikoff's and Roux's discovery of the value of calomel ointment as a preventive medium should attract the attention of all medical men. The present little volume gives in an admirably concise manner an account of the brilliant work which has been carried out at the Pasteur Institute. The early chapters deal with syphilitic contagion and generalization of the virus, and it is interesting to note in this connection that (experimentally) gummata are rarely the starting-point of syphilitic infection, and also that the lesion which is the port of entry must be dermo-epidermal. The section devoted to the virus sums up our present knowledge of the *Spirochæta pallida*. It is, however, the section devoted to the action of mercury as a direct prophylactic agent which is most engrossing. The experiments on monkeys demonstrated the great influence which fatty mercurial preparations had on preventing the usual train of symptoms in the inoculated animals. The experiments on man are of greater interest, seeing that it was the author himself who, sincere in his belief of the great Frenchmen's experiments on members of the Simian tribe, offered himself for experiment. This devotion to the cause of medicine, the subsequent great proof of the savants' premises repaid, and we congratulate the author no less on his courage than on the excellent manner in which he has set down in print the experiment. The translation is well effected, and the arrangement of "conclusions" at the end of each chapter is much to be commended.

Correction.—Price of Dental Histology reviewed in last number should read 15s. net, or 7s. 6d. each volume

Preparations, etc.

We have received some samples of the Eustace Miles' Proteid Foods, accompanied by a fund of "literature." The E.M. Proteid Food is certainly rich in nourishment, the proportion of proteids present being over 30 per cent., the carbohydrates over 40 per cent., and the fats about 10 per cent. It is palatable and easily prepared, a twofold advantage. The Infant Food is a well-proportioned preparation, whilst the Cocoa and Biscuits each show a goodly percentage of nourishing elements, and the former has the advantage of being cheap.

Books Received.—Kingston Fowler and Godlee's Diseases of the Lungs; Notter and Firth's Hygiene, new edition; Leathes' Problems in Animal Metabolism; Halliburton's Biochemistry of Muscle and Nerve; Eden's Midwifery, new edition; Tomes' Dental Anatomy; Cunningham's Practical Anatomy, new edition; Jellett's Gynæcology; Turner's Pocket Osteology; Mackenzie's Diseases of the Throat, Nose, and Ear; Schrötter's Hygiene of the Lung; Robertson's Medical Jurisprudence, Toxicology and Public Health; Vol. I.—Embryology, Quain's Anatomy, new edition; Norman Walker's Introduction to Dermatology; Keiths' Cancer; Home Nursing.

Pass List.

ROYAL COLLEGE OF PHYSICIANS OF LONDON, April, 1908. — Examination for the Membership: Robert Alexander Chisolm, M.A., M.B. Oxon. Elected to the Fellowship: Theodore Fisher, M.D. Lond.

FINAL CONJOINT EXAMINATION.—Medicine and Surgery: *C. S. E. Wright. Medicine only: F. Holcombe Fuller, E. P. L. Hughes, E. L. W. Mandel, *B. Muir, M. K. Nelson, W. G. Pinching, P. Seymour Price, L. L. C. Reynolds, R. P. M. Roberts. Surgery only: *A. Davidson, J. B. Dunning, T. Evans, *A. W. Ewing, *F. J. Kolaporwalla, *C. E. Price, *A. V. Ledger, A. H. V. St. John, *B. Wallis. Midwifery only: F. R. L. Atkins, F. J. Cutler, V. P. Hutchinson, K. H. Hole, C. C. Holman, H. I. Janmahomed, H. R. Mullins, P. V. G. Pedrick, *H. A. Sanford, W. G. Tucker, J. Walker, F. J. Wheeler.

*Denotes completion of Examination.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—Licence in Dental Surgery. — First Professional Examination, May, 1908.—Mechanical Dentistry and Dental Metallurgy: H. F. Barge, C. H. Barnett, C. H. Bradnam, C. F. Constant, T. L. Fiddick, F. L. Furse, H. H. Glover, C. J. Henry, S. W. Ingram, H. L. Messenger, W. C. Miller, C. G. Morris, H. S. Morris, C. F. Moxley, C. H. G. Penny, J. M. Pomeroy, J. A. W. Stuart, W. E. Tanner, W. A. Thompson, H. Thornton, N. S. Heegaard Warner. Mechanical Dentistry only: G. V. Dymott, F. H. Edey, N. Edgar. Dental Metallurgy only: R. B. Campion, R. Curle, K. G. Hoby.

FINAL EXAMINATION FOR THE LICENCE IN DENTAL SURGERY, May, 1908.—Parts 1. and II.: P. S. Harrison, W. A. James, L. A. B. King, A. L. Saul, E. Smith, E. E. Solomon. Part I. only: S. W. Charles, P. C. Charlton, A. Cohen, L. B. Griffin, A. Samuel, R. W. Morrell, H. S. Pugh, H. G. Spain, W. E. A. Tibbalds. Part II. only: *W. F. Boxall, *S. W. Chetwood, *F. N. Doubleday, *A. M. Henry, *C. C. Jones, *V. Masters, *W. Grant Oliver, *J. R. Palmer, *W. S. Rutter, *H. P. Tait, *R. M. Wormald.

* Denotes completion of examination.

Change of Address.

Lieutenant Brooke Churchill, R.A.M.C., from Meerut, India, to Chakrata, India.

Dr. E. M. Harrison, from Wentworth House to 45, New North Road, Huddersfield.

Mr. A. M. Henry, L.D.S. Eng., from Guy's Hospital to 63, Sandgate Road, Folkestone.

Mr. W. R. Ransford, L.D.S. Eng., from the Officers' Mess, 90th Punjabis, Rangoon, to the Civil Hospital, Maymyo, Upper Burma.

Dr. W. H. Robinson, from Landieu, Hartburn, Stockton-on-Tees, to Croft House, Moorgate, Rotherham.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Sport.

Cricket.

The prospects of the 1st XI. for this season seem quite cheery. Although the fearful weather of the past fortnight has delayed net practice, the ground is in excellent condition, and many men have taken advantage of the few fine days. The first match was not a great success, but yet the team showed promise. Freshmen ought to be to the fore this year, as there is a probability of five places requiring filling. Let us remind them that keenness at the nets is no small factor.

Provided this keenness is forthcoming, we should indeed shape well and give a good account of ourselves, not only in our Club Matches, but also in the Hospital Cup.

GUY'S v. STOICS.

Played at Honor Oak Park on Saturday, May 9th, and ended in a win for the Stoics by 85 runs. Our bowling was very weak, with the exception of Kahlenberg, and he was not favoured with the best of luck. Scores:—

STOICS.

G. H. Gadsdon, b Tooth	0
W. F. Faviell, c & b Tooth	68
G. M. Hardy, c Fox, b Medlock	23
C. Haywood, c Saner, b Kahlenberg	33
F. Paine, b Kahlenberg	3
F. W. Hayward, lbw, b Tooth	3
D. Robertson, b Kahlenberg	13
O. C. White, c Rook, b Medlock	8
S. Brookelbank, b Kahlenberg	7
H. A. Budden, lbw, b Kahlenberg	0
E. S. Snell, not out	3
Extras	12
Total	173

GUY'S.

M. M. Munden, lbw, b White	27
R. Montgomery, b Haywood	3
W. E. Fox, c Robertson, b White	8
F. D. Saner, b Haywood	4
C. H. Medlock, b Haywood	0
H. Lee, b Haywood	11
N. E. Farr, ht wkt, b Haywood	5
A. C. Rook, not out	12
W. T. Clarke, b Haywood	9
F. Kahlenberg, c White, b Haywood	2
F. Tooth, c Faviell, b Haywood	4
Extras	3
Total	88

GUY'S v. SURREY CLUB AND GROUND.

This match was played at Honor Oak Park on Wednesday, May 13th, and ended in a draw. Guy's won the toss, but were unfortunate to lose Charlton in the first over. The next wicket fell for 100, Chase being stumped after making a good stand with Munden. Other men who showed form were Gibbons (24) and Birks (23),

the whole side being out for 180. After dismissing four of our opponents for 53—thanks to the good bowling of Charlton—we were unfortunately stopped by rain, and although play was resumed later on, the bowlers were never able to get a grip of the ball, and a match which at one time seemed to be in our hands was left drawn. Scores :—

GUY'S.

P. C. Charlton, c Steadman, b Smith	0
M. M. Munden, run out	63
R. G. Chase, st Steadman, b Blacklidge	46
W. E. Fox, c Baker, b Spring	11
H. V. Gibbons, c Odell, b Spring	24
R. Montgomery, c Steadman, b Spring	4
A. H. Birks, c Steadman, b Spring	23
C. H. Medlock, c Steadman, b Spring	0
T. Clapperton, not out	6
F. Kahlenberg, b Smith	1
F. Tooth, b Smith	0
Extras	2
Total	180

SURREY CLUB AND GROUND.

Hon. S. R. Beresford, lbw b Charlton	0
Baker, lbw b Kahlenberg	15
Steadman, b Charlton	21
Blacklidge, c Tooth, b Charlton	59
Spring, c Fox, b Kahlenberg	4
F. Odell, b Chase	23
Maj. Louis, run out	1
A. L. Sloper, not out	6
Smith, not out	2
Extras	6
Total for 7 wickets	137

C. S. G. Lloyd and Reed did not bat.

Swimming Club.

Water Polo.

GUY'S v. H.A.C.

Played at Southwark, on Friday, May 8th, and resulted in a win for the H.A.C., after a very pleasant game, by five goals to four. We were without Glover, McSaunders and Rice. Defending the deep end first, we at once scored through Moberly, and later on he added another. Our opponents scored thrice, and led at the interval by 3—2. The second half was very even, both sides scoring two goals. Our goals were scored by Ball and Clarke. Moberly, with a little practice, should prove a great acquisition to the side. Team :—

GUY'S.- H. N. Eccles (goal); G. G. Pritchard and W. T. Clarke (backs); M. E. Ball (half-back); T. P. Cole, H. Moberly and H. E. Perkins (forwards).

NOTICE.—An extraordinary general meeting of the Swimming Club will be held next Friday, at 4 p.m., in Class Room I. (Physiology Block), for the purpose of electing a new Hon. Secretary. All men are invited.

Lawn Tennis.

The prospects of the Tennis teams are good, and with a bit of practice we may add yet another trophy to the Smoking-room.

The 1st VI. are the same as last year, with the exception of A. Zorab, his place at present being filled by R. Curle.

We have a good list of fixtures, twenty-two 1st VI. and thirteen 2nd VI. matches.

In the trial match Curle gave a good display, K. Long, Billing, and Holman being also seen to advantage.

Last Saturday we were badly beaten by West Dulwich by 7 matches to 2. This being the first match of the season, we were not seen at our best owing to lack of practice.

Last Wednesday the 1st VI. beat Hadley Wood by 5 matches to 1, three games being undecided. M. M. Adams, although suffering from tæno-synovitis, made a welcome reappearance.

Rifle Association.

The first shoot of the season took place at Bisley, on Wednesday, May 6th. In spite of the unfavourable meteorological conditions, a very fair number turned out.

Result of handicap Sweepstake :—

		Winners of
L. L. C. Reynolds	91½	1st Sweepstake.
W. E. Wallis	87	2nd "
H. J. Henderson	85	
H. L. Attwater	82	
W. Robinson	81½	
G. A. Blake	81	
F. D. Annesley	79½	
E. Billing	79	
D. C. Druitt	79	
M. K. Nelson	—	

At a Committee meeting on May 8th, W. Robinson was co-opted as a first-year member to serve on the Committee, and F. D. Annesley as first-year representative on the Miniature Rifle Range Sub-committee.

Births.

MURIEL.—On May 9th, at 109, Scotch Street, Whitehaven, the wife of G. Bertram Muriel, M.B., B.C. Cantab., M.R.C.S., L.R.C.P., of a daughter.

OSBORN.—On May 5th, at Ennismore Lodge, Park Avenue, Dover, the wife of Francis Arthur Osborn, L.R.C.P. Lond., M.R.C.S. Eng., of a daughter.

Marriages.

HARRISON—QUIHAMPTON.—On Saturday, April 25th, at St. Mary's Church, Spring Grove, Isleworth, Edward Montague Harrison, M.B., B.S. Lond., M.R.C.S., L.R.C.P., to Sybil, third daughter of W. G. Quihampton, Esq., of Osterley Lodge, Isleworth.

THOMAS—PRICE.—On April 29th, at St. Peter's Church, Carmarthen, by the Lord Bishop of Swansea, assisted by the Rev. D. T. Alban, B.A., Frank G. Thomas, B.A., M.B. Cantab., to Florence M. S. Price, M.B., Ch.B., elder daughter of Dr. and Mrs. Price, Carmarthen.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

May.
Sat. 30. 1st XI. v. Bexley (Away).
2nd XI. v. U.C.S. Old Boys (Home).
June.
Mon. 1. Special Clinical Lecture by Mr. Eason (Ophthalmology), at 1.15 p.m.
Last day of admission to Inter. Sci., Pre. Sci., Inter. Med., and M.S. Examinations, London University.
July Appointment List opened.
Tues. 2. Examinations for Treasurer's Gold Medals begin.
Wed. 3. Derby Day.
Thur. 4. Messrs. Lane and Fagge's Take-in commences (Messrs. Walker and Densham).
Fri. 5. Water Polo v. Otter Club (Home).
1st XI. v. Thespids (Home).
Mon. 8. Bank Holiday.
Tues. 9. July Appointment List closed.
Wed. 10. Annual Sports at Honor Oak Park.
Water Polo v. Cambridge (Away).
Thur. 11. Messrs. Dunn and Rowland's Take-in commences (Messrs. Henderson & Chase).
Water Polo v. Sydenham (Forest Hill).
Fri. 12. Dental Bacteriology Examination for Second Year's Men.

Passim.

ON another page will be found an account of the Annual Meeting of the Guy's Hospital Ladies' Association. It is more than satisfactory to read of the good year, both financially and otherwise, which the Association has just completed. The work carried out by this Society needs no praise from our pen, for one and all of us realize the great amount of practical philanthropy which emanates from this source. Thousands of patients owe those ladies who so kindly give their time and labour to the making of garments, a huge debt of gratitude, and it is no exaggeration to say that the Association takes "a definite part in the complete restoration to health, which is the Hospital's ultimate object"; for, apart from supplying clothing to them as in-patients, they also supply the garments necessary for those patients who are sent to Convalescent Homes, and who might often refuse the offer to go, on the score of insufficient clothing. We might add that the furniture supplied by the donation of the Association for the balconies has proved a great boon and been much appreciated. This year there has been voted £300 for the maintenance of six beds in Victoria Ward. It is the aim of the Association to support the ward entirely—there are eight beds in all—and we have no doubt that if the interest already evinced is maintained, this will be accomplished before very long.

THE recent honour shown to Miss Florence Nightingale recalls strongly to mind the events which led to her forming the determination to go out to the Crimea. A letter from William Howard Russell had a marked effect on the English people; it drew a realistic word-picture of the sufferings of our soldiers, and concluded with the words, "Are there no devoted women amongst us able and willing to go forth and minister to the sick and suffering soldiers of the East in the Hospitals of Scutari? Are none of

the daughters of England, in this supreme hour of need, ready for such work of mercy?" These words reached Florence Nightingale in her Derbyshire home; her womanhood was roused, the spirit of patriotism awakened. Within a fortnight, with a devoted band of helpers, she sailed from England. How the carping Mrs. Grundys sneered. "Tush! A young unmarried lady going out as a hospital nurse to soldiers!" For remember, the nurses of those days were akin to Sairey Gamp. We all know how she was received, how every soldier worshipped her very shadow. The death-rate decreased, during the time these devoted women were there, from 60 per cent. to 3 per cent. The tact and sympathy of a woman had done what our unwieldy official machinery had been unable to cope with. Verily, as Oliver Wendell Holmes says, "A woman goes into sick room a woman, and she comes out an angel."

All this is of interest, for from that day there commenced a new epoch in nursing; its enormous development dates back to this episode. How great, then, is the world's debt to this brave woman, for the modern nurse is a wonderful thing, and a good nurse is as essential to a patient's recovery as a good doctor. May this grand woman live for many years yet, to enjoy the honours which a grateful country bestows on her!

Lord Mount Stephen, by his magnificent gift to the King Edward's Hospital Fund this week, has brought his contribution to the Annual Income up to over £30,000 per year. This raises the total Annual Income of the Fund from investments to almost £60,000. This princely benevolence, together with the subscriptions and annual income from other sources, will probably bring the sum for distribution this year close upon £135,000. The Fund is a monument to English charity; its humane aim and real practical value should be object-lessons to those philanthropists who scatter more or less indiscriminately their benevolences for purposes less beneficial to humanity. That our great hospitals are maintained by public benevolence is always a great source of admiration to foreigners, and such a gift as Lord Mount Stephen's should be a matter of pride with us. May many follow his lead!

Our readers will be pleased to hear that Sir Samuel Wilks' condition continues to improve. On June 2nd, he completes his 84th year, and we take this opportunity, on behalf of his many friends amongst us, and many of his old pupils, to again wish him the speediest of recoveries and every happiness for many years to come.

The Annual General Meeting of the Debating Society will be held on June 2nd, at 12 noon, in Class Room III., Physiology Block. Mr. A. R. Thompson will take the chair. Officers for the ensuing year are to be elected, and other matters considered. It is hoped that there will be a big attendance.

Mr. J. T. Smalley, owing to an attack of appendicitis, has had to relinquish his work as Mr. Dunn's H.-S.; Mr. H. J. Henderson is acting in this capacity at present. We sincerely hope that Mr. Smalley will be soon himself again. It is remarkable, of late, how many of the Residents have, owing to indisposition, had to be warded. The strenuous twelve or fifteen months of unbroken appointments tells its story.

Some out-patients have a decided sense of humour; but the one who came up one day last week to see one of the House Surgeons surely bears off the palm. She was asked to wait a minute or two whilst he attended to some more urgent matter. On his return she had disappeared. He inquired of one of the other patients of her whereabouts, and was apprised of the fact that she said she had felt sick and had gone home.

The Annual Dinner of the Colonials at Guy's is to be held on Thursday, 11th June, at the Trocadero. The Secretaries are anxious for this year's dinner to beat all records. All Colonials and those who have interests in the Colonies are expected. Tickets, 6s. 6d. each, may be obtained from Messrs. R. Stout and B. Stringer.

To-day sees the departure of still one more familiar face amongst the employees about the

A Guy's Poet.*

It is refreshing to see a volume of poems in these degenerate days. We had thought the world gone wild over motor cars, balloons, radium, and other mundane things, with a more or less intolerant attitude towards that branch of literature which poets favour. It shows much courage, and a profound faith in human nature, that Dr. Lulham has ventured to put this charming volume into the hands of so callous a generation. We have read every line with the utmost care, and we venture to say that those who will take the trouble to dip into the pages will be amply repaid.

How a volume of poems should come to be reviewed in Guy's Gazette may seem strange to some, but the matter is simplified when we state that the writer is a Guy's man, who knows all that is implied in the terms out-patients, operating theatre, and wards.

It is wonderful to us that he has gone behind and beneath all these experiences, and has felt his way with such power in regions unusual to the scientific man. Every side of human nature, dark as well as bright, passes under review. Here and there we have the glimpses of the seer, who lifts the veil for us, and interprets the hazy future to which things tend.

A characteristic of the writer is his cheery optimism. Only once in the whole book is the word pessimism uttered, and even there, strange to say, he overlays its dull grey colours by his tints of brightness. Speaking of pessimists, he says :—

> "Oft 'neath your shell of rugged speech,
> Born of the fret of human pain,
> Compassion lies impearled."

His notes of gladness, of hope and faith, are an inspiration, and fortunate must those sick ones have been by whose bedside he ministered. Constant contact with pain and sickness must naturally tend to depress; but he who strikes a hopeful note, and trains himself to seek for and dispense the brightest and best, is of the salt of the earth.

Another marked feature of these poems is the intimate knowledge of Nature manifested by the writer. A downright passion for field and fell, down and dell, sea and sky, bird and flower, gale and zephyr, is revealed throughout. One cannot fail to be impressed with his close study, and minutely careful observation of everything Nature has to show. Moreover, it is not the book of the scientific man alone, but that of a veritable lover of Nature. He reads into the various phenomena, with true poetic insight, the lessons they are designed to teach of beauty, order, design, generosity, innocence, love.

The very title of the book is refreshing. There is a sort of "Back to the land" air about it. The poem on "The Downs," where evidently the youth of the writer was spent, reminds us strongly of some of the finest passages in Thomson's "Seasons." One wonders why towns and cities draw to such an extent, when Nature is presenting her beauties in an interminable series so close at hand. It is a fact to be greatly deplored that such scenes as the writer depicts in Surrey and Sussex should be, so to speak, running to waste, with the sparsest of population to enjoy them. In one of the most beautiful poems in the collection, "Will there soon be nine?" (p. 28), the powerful sympathies of the writer for the slum-child are clearly shown :—

> "Straight from reeking slums they brought them
> Children—to our fields and flowers;
> Drawn by happy cries I sought them,
> Helped them speed the laughing hours."

He further finely depicts the pale-faced slum mite standing in a fairy ring, with a handful of foxgloves, and counting the stars till there should be nine. She had been told that the fairies would appear when she could count nine, and her agony was great as she neared the number and heard the bell summoning her to the station :—

> "Then we heard an angry call
> For the little one belated,
> And they dragged her from it all."

Besides nearly forty poems occupying the body of the book, there are twelve charming sonnets which will bear reading any number of times.

The poem "On the Downs" is the longest in the book. It is brimful of beautiful imagery and irrepressible optimism. Speaking of the hills around the home of his boyhood, he says :

*"Songs from the Downs and Dunes." By Habberton Lulham. (Kegan Paul, Trench, Trübner & Co., London.)

"O perdurable hills!
Blessing your root-fast changelessness amid
A world of change and loss. But brood no more,
My heart, life still shines rich with others' hopes
and loves."

The fairy song on page 12 is a gem, and one of the very finest in the book. It reminds one of the light and airy fancies of Shakespeare's Queen Mab. The poem contains eight stanzas. The third, in which the Queen is ordering some of her fairies to procure a blue extract, says:

"And some, to make the colours,
We drop in babies' eyes,
Must steal the soft blue wing-dust
From sleeping butterflies,
To mix with azure essence
Of speedwell, violet,
And that small lovers' blossom
That bids them not forget."

Another beautiful poem, compact, well-imagined and well expressed, is that "To Whymps" (page 44). The opening verse runs:

"Little ones, stay the flying years,
These good years I must sadly see
Glide hastening past, though each appears
Still lovelier than the last to me."

The little one is sent to each of the seasons to beg them to stay. What can be finer than

"Old Time himself shall scarce withstand
Your tender witcheries, little one;
So tilt his hour-glass in your hand,
And make the gold grains slower run."

The "Bootblack," on page 66, is full of tender sympathy. The writer's choice of expressive words and phrases is well seen in the second stanza—

"Yet who knows for whom what employ may be meet?—
One remembers of old-time a washing of feet—
And the heft bolt may hold half the strength of a knife,
Or the lowliest task prove a linch-pin of life."

"Joys Unprized," on page 73, is a striking poem, clear, stimulating, and gently rebuking.

The twelve sonnets exhibit much power, great sympathy, and finished expression. The writer is seen at his best here. They will bear reading over and over, and each time fresh truth leaps from the page.

In "Reveillé" we have strong, striking similes and good picturing power. The poem is like a speaking canvas, especially the second stanza.

There is a fine philosophy of life in "To each his own." Each soul, by its constitution, has certain capacities, and is adapted to respond to particular influences. Like a musical glass or a pianoforte wire, it responds to the vibrations producing its own note.

"Music's Incantation," is one of the finest of the sonnets, and possesses great depth of feeling. It deals with the influence of music upon the soul. Past joys and sorrows, sins and magnanimities rise into consciousness as music works its incantations.

"The Star of Suffering" puts forward that there are no earthly joys without toil. Is it that life's bitterness, disappointment, and pain are the divine chemicals for producing the elixir of eternal joy?

"The Wardress" shows that often the noblest qualities in a woman are undeveloped or repressed by beauty, which tyrannically holds them in check. Her fate when beauty departs is pitiful.

"Deliverance" shows how night is a blessing, drawing its friendly curtain over the day's worries and disappointments. It enables us to face the world again with freshness and renewed hopes. The sonnet finishes with a fine passage—

"Whose splendour floods with light
This temple of my soul, which now I turn
In reverent orientation to its sun,
And therein stand assoiled. Thank God for night."

"To the Death" contains some striking antitheses, portraying the life-long struggle between a man's better and worse self.

"Great God! her prayers, his answering ribaldry!
Her chants that rise while his low cursings roll!
Cool springs of love, fierce lusts like burning coal,
High hopes, foul fears, all in my bosom be."

"The Last Help" depicts the needs of the soul when life draws to a close. He prays to be able to recall the hallowed courage with which his mother faced death.

No thoughtful mind can peruse the volume of poems without profit. One feels in contact with the beautiful, the good, the wise, the true, the noble—everything that uplifts.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated.*

Aspects of French Medicine.*

By Dr. Hertz.

II.

Clinical Methods.

Ninety-three years ago Laennec demonstrated his newly-invented stethoscope to the Académie de Médecine in Paris. To-day the stethoscope is looked upon as the most essential instrument of diagnosis by physicians in all parts of the world, with the single exception of the country of its discoverer. During three months spent in the Parisian cliniques, I did not see a single stethoscope. It is the universal practice of physicians to employ direct auscultation only, and the use of the stethoscope is not even taught to students. As a rule, a towel is put over the skin, and the examiner applies his ear to the towel, but I have frequently seen an impatient physician place his head in direct contact with the skin, even in the case of dirty out-patients or patients in the wards suffering from infectious disease, such as typhoid fever and measles. On the other hand, one of the most distinguished physicians in Paris, who has written a treatise on disorders of the circulation in eight large volumes, and whose teaching on diseases of the heart is as much appreciated in England and Germany as it is in France, almost invariably examines his out-patients without causing them to remove their shirts. He then proceeds to discuss the case, makes a diagnosis, and prescribes without inspecting, percussing or palpating the bared chest. I have seen on several occasions a hemiplegic patient come into one of the nerve cliniques, where the physician, after listening to his chest through all his clothes, including often a thick overcoat, has pronounced his heart to be normal, and has then excluded cerebral embolism as a cause of his paralysis.

It is obvious that the apices of the lungs cannot be properly auscultated by the direct method, and that anything approaching exact localisation of abnormal physical signs, especially in infants, is quite impossible. I heard no explanation of the complete disuse of the stethoscope, the majority of physicians never having listened through one at all. Owing to the unsatisfactory methods of physical examination of chest cases, one is inclined to read with scepticism the voluminous writings of the Parisian school on the diseases of the lungs and heart.

The investigation of diseases of the alimentary canal is much more thorough than that of diseases of the thorax. In those hospitals which have a special department for gastric and intestinal cases, the clinical examination is most excellent, though it is perhaps doubtful whether the knowledge gained after many hours of laboratory work on the gastric contents and on the fæces is often worth the trouble. It is possible that rather more cases of early malignant disease are recognised in Paris than in London, but on the other hand, many cases of nervous origin must be made worse by being encouraged to take too much interest in the processes going on in their alimentary canals. The numerous advocates of psycho-therapeutics in Paris go to the other extreme, as in their desire to direct the patients' thoughts into more normal channels, they sometimes refuse to examine the abdomen at all, so that doubtless a good many cases of organic disease are not recognised until too late by followers of this method. The detailed chemical examination of the gastric contents in cases which are not organic in origin has the further disadvantage of tending to make the investigator pay too great attention to slight variations from the supposed normal, which he tries to correct by means of acids or alkalies, instead of attempting to find out and to treat the underlying abnormality in the patient's general condition.

Much more time is devoted in the Parisian hospitals to the laboratory investigation of disorders of metabolism than in England; but, owing to the less reliable methods employed, the results obtained cannot be looked upon with the same confidence as the work which comes from the German kliniks.

The modern methods of investigating renal diseases by the cystoscope and the segregator, and by the new tests of the functional capacity of the kidneys, are much more frequently employed than in England. Here again, though nobody can deny the immense value of the cystoscope and segregator, the often laborious investigations into the functional powers of the kidneys only rarely give results which have any practical value as a help to diagnosis or treatment.

Whatever may be thought of the condition of French medicine as a whole, there is no doubt that Paris is still, as it has been ever since the days of Charcot, the greatest school of neurology in the world. The enormous material collected in the two great infirmaries, the Salpêtrière and the Bicêtre, and the large number of excellent out-patient cliniques afford an opportunity of

* Part I. was published in the Gazette on April 18th.

studying nervous diseases which is unrivalled in any other city.

One cannot complain of the lack of thoroughness in the examination of cases in some of the nerve cliniques. In a certain clinique, every out-patient, whether male or female, is completely nude when examined. Though this practice is most objectionable in the case of women, it has yet led to the discovery of many valuable signs, which would never have been observed if patients were always decently clad. Thus in a clinique in which patients do not undress completely, the socks would rarely be taken off, and Babinski's sign would never have been discovered. The gait of a patient can also be only studied properly if he is wearing less inconvenient clothes than those ordinarily supplied in the Guy's wards when it is desired to see a patient walk. The routine examination of the abdominal and cremasteric reflexes sometimes gives valuable aid in diagnosis, and in difficult cases a conclusion can often be made in half the time by the more sensible, though more indelicate, French method of examination.

Just as in England the stethoscope is considered to be an absolutely essential instrument for examining the chest, so in France the percussing hammer is regarded as indispensable for examining the nervous system. Such an instrument is, it is true, occasionally seen in England, but the majority of physicians do not use it, and the French pattern is much heavier and more effective in eliciting tendon-jerks than that obtainable from English instrument makers. I have myself found Déjerine's hammer of the greatest service since my return to England. With it, it is possible to obtain the tendon-jerks of the arm with ease, and I have several times been able to demonstrate a knee-jerk when the ordinary method of examination had failed to produce one. Moreover, the tendo-Achillis jerk, the absence of which is always pathological, can only be obtained with certainty in normal individuals with its aid, as it is often stated in English text-books that the jerk is not always present in health. The absence of the tendo-Achillis jerk is of more importance than that of the knee-jerk, as it disappears before the latter in the majority of cases of tabes and neuritis.

Lumbar puncture is performed much more frequently in Paris than in London, and the results obtained are often a very valuable aid in diagnosis. Thus the cerebro-spinal fluid of out-patients, who are thought to be suffering from very early tabes or general paralysis, is always examined, as an excess of lymphocytes is present in these conditions and in all syphilitic cerebro-spinal diseases, but never in disseminated sclerosis and other non-syphilitic organic diseases, nor in hysteria. The puncture is always made exactly in the middle line, and I can testify to the greater efficacy of this than the lateral puncture generally recommended by English authorities. Patients who are sufficiently well, instead of lying down, stand with their backs bent forward and hands pointing to the ground during the puncture. Lumbar puncture is also recommended by some French authorities in the treatment of intractable migraine, Menière's disease and uræmic headache.

It is to the Parisian school that we owe most of our knowledge of the diagnostic importance of the cytological examination of exudates such as pleural effusions, in addition to that of the cerebro-spinal fluid. The centrifugalised deposit from exudates is examined as a matter of routine, and a diagnosis of tuberculous disease is often made largely as a result of finding an excess of lymphocytes.

Hysteria is much more common in France than in England, and it is in France that the greatest advances have been made in recent years in our knowledge of its causes, diagnosis, and treatment. First of all, I learnt from Babinski, whose Wednesday morning out-patient clinique at the Pitié is, in my opinion, the medical event of the week in Paris, a definition of hysteria which, I think, is invaluable for the proper understanding of the subject. It is this: hysteria is a pathological state of the mind, in which abnormal conditions of the body can be produced by suggestion on the part of the individual himself or of someone else, and in which such abnormal conditions can be removed by the exclusive influence of persuasion. I learnt in Babinski's clinique to appreciate how this conception of hysteria helps in its diagnosis and treatment, and my experience since my return to England has abundantly confirmed me in my belief in its value. Thus, in examining a case of hysterical paralysis, it is frequently possible to obtain evidence of its true nature from its form and distribution, which correspond more to lay conceptions of paralysis, and so to what a patient would be likely to produce by auto-suggestion than to the genuine results of organic nervous disease. An example of this is afforded by a most valuable sign, which I learnt from Babinski, and which I have found of help on several occasions in the diagnosis of hysterical from organic hemiplegia. The patient lies down with his arms folded and legs widely apart, and then makes an effort to sit up, after which, with

his arms still folded, he is told to let himself fall sharply back on to a pillow. A normal individual raises both his legs on sitting up and in lying down in this way. In a case of organic hemiplegia, the paralysed leg rises higher than the healthy limb. This is not what the uninitiated would expect, so that it is hardly surprising that in all cases of hysterical hemiplegia the paralysed leg remains flat on the couch, both on sitting up and on lying down, although the voluntary action of some of the very muscles supposed to be paralysed are required for the purpose. A similar sign, which is also due to Babinski, is concerned with the platysma, the contraction of which can be readily seen on watching the neck after telling a patient to try to yawn. In organic facial paralysis the platysma is generally affected; in functional paralysis it is always spared, as the platysma does not come within the anatomical knowledge of the layman.

Not infrequently considerable difficulty is experienced in deciding whether a patient is suffering from genuine epilepsy or from hysterical attacks. If one has the opportunity of being present at a fit, it is generally easy enough to make a confident diagnosis. But much more frequently we have to depend upon the story told by the patient herself and her friends, who are generally themselves too much excited during the fit to be able to give a really accurate description of it. In Paris, where hysterical fits are of much more frequent occurrence than in London, the difficulty arises more often. Babinski makes it a practice, in any case in which the least doubt exists, to attempt to produce a fit by suggestion. This can never be done in genuine epilepsy, but in hysterical cases it is generally easy to produce convulsions by applying faradism to the neck or abdomen, and telling the patient she is about to have a fit. If a fit occurs, Babinski seizes the opportunity of suggesting a cure, by telling the patient during the attack that she will never have another, and that she will come round at some given signal; she accordingly recovers consciousness immediately if he claps his hands or blows upon her face.

A nineteen year old girl was among my out-patients on April 27. She had had a fit on April 17 and about twenty since then. I could get no clear account of them from her friends, but she described an aura of a cold sensation on the forehead. In order to ascertain whether the fits were hysterical, I attempted to produce one by putting my thumbs dipped in cold water on her forehead so as to simulate the aura, and telling her she was about to have a fit. Immediately afterwards she had one. I then told her she would have a second one, which would be her last, the next day at my demonstration of nervous cases. There I produced one with more difficulty, having to use faradism in addition to mere verbal suggestion. On May 20 she told me she had had no more fits.

Before my visit to Paris I had been much struck by the frequency with which a careful examination revealed the presence of hemi-anæsthesia in hysterical patients. In quite nine out of every ten cases of hysteria I found that the patient felt less clearly on the side in which the paralysis or other abnormal condition existed. The anæsthesia frequently extended over the whole of one side of the body, including the conjunctiva and mucous membrane of the tongue, palate and pharynx. The anæsthesia was for touch, temperature, and pain, and there was often an impairment of the muscle sense. Associated with the hemi-anæsthesia was a narrowed field of vision of the corresponding eye, and frequently complete loss of smell and taste and defective hearing on the same side. This combination was clearly pathognomonic of hysteria, as no organic lesion could produce it, and even without the affection of the special senses the hemi-anæsthesia of the skin and mucous membranes was most suggestive. That the anæsthesia was genuine and not feigned was proved by the absence or diminution of the plantar, cremasteric, abdominal, conjunctival, and pharyngeal reflexes on the anæsthetic side. Most striking was the loss of the reflex which gives rise to sneezing and lachrymation on sniffing ammonia up one nostril.

I had always imagined that part of the anæsthesia was the result of suggestion on my part, but I was surprised to hear from Babinski that in his opinion hysterical anæsthesia and impairment of the special senses is *never* produced by auto-suggestion, but is always due to suggestion by the observer. The demonstration of some thirty cases in his clinique and the observation of numerous patients since my return to England have convinced me that he is right. If the examination be made in such a way as to preclude the possibility of suggestion no abnormality will be found in the senses of hysterical patients. The patient's eyes being closed, he is told to touch with his forefinger the spot on his body touched by the observer. Localisation of tactile sensation being found to be normal, he is told to say whether he is touched by a blunt or sharp instrument, and subsequently he is asked whether an object is hot or cold. Finally

something is put in his hand for recognition, and his fingers or toes are moved in order to test the muscle sense. The special senses are also tested without any comparison between the two sides being made. Using this method in a large number of cases, I have come to the same conclusion as Babinski, that in hysteria there is no impairment of the senses due to auto-suggestion.*

After this preliminary examination, I proceed to examine the patient by the more usual method which I was in the habit of using before I went to Paris. I touch the patient in corresponding points on the two sides of his body, his eyes being open, and I ask him on which side he feels more distinctly. Having some hysterical paralysis, rigidity, or pain on one side, this method of examination immediately suggests to him that sensation is likely to be less distinct on the same side. Almost invariably he says at once that he feels less distinctly on the affected side. On continuing the examination in the same way the whole half of the body is found to be deficient in the perception of all sensations. At the same time I have frequently observed that a cutaneous reflex present immediately before the examination has disappeared after the suggestion has produced anæsthesia. It might be argued that this method reveals slight differences in sensibility which the first method is too inexact to discover. But it is easy to prove that this is not so, as the amount and distribution of the anæsthesia can be varied at will by the observer. Thus, in several of my recent cases, instead of suggesting an ordinary hemi-anæsthesia, I have suggested with equal ease anæsthesia of one side of the body in front and of the other side behind. I believe it would not be untrue to say that if anybody wished to invent a new sign or "stigma" of hysteria, he could do it by merely suggesting the same symptom in every patient. If, for example, he said, in the presence of his hysterical patients, that such cases have always anæsthesia to temperature of the big toe of the left foot, he would certainly find such anæsthesia present. It is thus merely owing to the customary method of examination that hemi-anæsthesia of the skin, mucous membranes, and special senses has come to be regarded as pathognomonic of hysteria, my "crossed anæsthesia" or the anæsthesia of the left big toe being equally pathognomic, as suggestibility and not the symptom is the pathognomic sign. In any doubtful case of hysteria, whether the symptoms be of the motor, cardiac, or digestive systems, I now always try to produce some form of anæsthesia by suggestion, and, if I suceeed, I look upon the case as being partly, if not entirely, hysterical.

* I have recently seen a case of hysterical hemiplegia with hemi-anæsthesia in which, I am sure, the anæsthesia was not produced by me. The patient had, however, some months before had crutch palsy with anæsthesia of organic origin; so it is easy to understand how, in this very exceptional case, anæsthesia as well as paralysis could have been produced by auto-suggestion.

Treatment.

The general methods of treatment in Paris appear distinctly old-fashioned to English eyes. Blistering, wet-cupping, dry-cupping, "points de feu" or the actual cautery, are all in daily use. It is rare to see a middle-aged Frenchman who has no scars on his body which are the result of one of these methods of treatment. I repeatedly saw the skin of the supra- and infra-clavicular fossæ of phthisical patients touched in some fifty places by means of a red-hot iron point. Blisters applied by the visiting physician himself are the routine treatment in many cliniques for pneumonia and all joint diseases. A patient with endocarditis or pericarditis would be fortunate to escape the cautery, cupping, or a blister.

In these days of short prescriptions and scepticism as to the value of drugs, it is remarkable to see how dearly the French physician still loves a long prescription, and how he believes in the efficacy of medicine. The following prescriptions are faithful copies of what was actually given by a professor of medicine in the faculty of Paris less than a year ago to a patient with a gastric ulcer:—

1. ℞ Solanine - - - 0·10 centigr.
Acide sulfurique dilué - 9·5
Picrotoxin - - - 0·01
Chlorhydrate de morphine - 0·05
Chlorhydrate de cocaine - 0·05
Sulfate neutr. d'atropine - 0·01
Ergotine Yvon - - 1·0
Eau chlorof. - - - 12·0
Mêlez et filtrez.
Two drops to be taken in water before meals.

2. Poudre d'yeux d'écrevisses } aa 3·0
Carb. du chaux precip. }
Magn. calcinée } - - aa 4·0
Bicarb. de sod. }
Poudre de bellad. - - 0·12
After meals.

3. A coffee-spoonful of Elixir eupeptique d'Eisy after each intermediate milk feed.

I heard the same professor dictate a prescription containing six different tinctures in the course of a clinical lecture on a case of acute gout.

In England the belief is steadily gaining ground that digestive ferments are rarely, if ever, indicated as treatment in gastro-intestinal

disorders. Even in cancer of the stomach it is now recognised that there is almost invariably sufficient pepsin present for gastric digestion, if the deficiency in hydrochloric acid is rectified. Moreover, the gastric juice would destroy any pancreatic ferments given by the mouth, even if it were possible to recognise the conditions in which they were present in insufficient quantity. But in France these ferments are constantly used. In a lecture on the treatment of heart disease, I heard the professor advocate the use of pepsin, papaïn, pancreatin, secretin, and enterokinase for the indigestion which may be present. Pig's gastric juice, sold under the name of gastrin, is used very extensively, and in one large ward containing mainly patients suffering from diseases of the alimentary canal, I saw at dinner-time a bottle of gastrin at the bed-side of a considerable proportion of the patients.

The enormous importance of the limitation of the amount of salt given to patients suffering from œdema or effusions into serous cavities was first taught in Paris, and it is mainly to Widal, who is one of the physicians at the Hôpital Cochin, that sufferers from nephritis are indebted for the more liberal diet which the acceptance of the salt retention theory of œdema has made justifiable.

It is very curious to see how differently mercury is administered to syphilitic patients in different countries. In England it is still almost universally given by the mouth, and the results obtained leave nothing to be desired. But on the Continent it is taught that to give mercury by the mouth is almost useless. In France it is generally injected into the muscles; this method has been adopted in the British army, where it is found very convenient, but in civilian practice it presents obvious disadvantages without any advantages over oral administration. In Germany it is universally given by inunction, a disgusting method which has nothing to recommend it.

The great value of calomel ointment in the prophylaxis of syphilis is the most important discovery which has been made by Metchnikoff, and his school in the Pasteur Institute during the last few years. Experiments on apes and on a medical student have shown that the application of the ointment to the penis within a few hours of the infection kills the virus, so that no primary chancre or later manifestation of the disease occurs.

I was much impressed by the excellent results obtained in Paris in the prophylaxis and treatment of diphtheria. Every child who comes to the out-patient department of the Hôpital Hérold, a children's hospital in which some 2,500 patients are treated annually, is given an injection of 1,000 units of anti-diphtheritic serum, whatever may be the matter with it. Since this plan was adopted about six years ago, the number of admissions into the large diphtheria wards has steadily diminished, and the number of cases of diphtheria occurring in the neighbourhood of the hospital is much smaller than in any other part of Paris, although formerly the disease was more prevalent than in most districts of the city. It is, moreover, claimed that the number of cases of simple pharyngitis and of tuberculous cervical glands has diminished during the same period, apparently as a result of this prophylactic serum treatment. The serum supplied by the Pasteur Institute is prepared so carefully that in only 5 per cent. cases does a rash follow, as compared with the 50 per cent. generally observed in England; the rash is, moreover, always urticarial, morbilliform and scarlatiniform rashes being unknown. Arthralgia only occurs in about 1 per cent. of the cases, whereas in England 5 per cent. is the ordinary proportion. Lesage, who is physician at the Hôpital Hérold, advocates the use of a single large dose of serum in all cases, at least 16,000 units being given at once in laryngeal diphtheria, and between 5,000 and 20,000 units in other cases, according to the severity of the attack. He also treats the laryngeal cases with injections of morphia, as he looks upon the obstruction as being almost invariably due to spasm alone, as post-mortem evidence and laryngological examinations made under an anæsthetic show that the membrane very rarely projects between the true vocal cords. By this treatment the patient is kept constantly asleep and tracheotomy is very rarely required. When the operation has to be done, he still gives morphia, as the spasm on removal of the tube is thereby prevented, so that, since the introduction of this treatment, he has not once experienced the difficulty, so frequently encountered in England, of getting rid of the tube. As the tube need only remain in the trachea for a very short period, he much prefers tracheotomy to intubation, which tends to increase rather than diminish laryngeal spasm. The result of the treatment of diphtheritia with one large dose of antitoxin, and of the laryngeal cases with morphia, is that the total mortality of many hundreds of cases under the care of Dr. Lesage is only 4 per cent., instead of between 10 and 20 per cent. in other French cliniques and in England, where smaller but repeated doses of antitoxin are given, and the

morphia treatment of laryngeal diphtheria is not employed.

I had frequent opportunities in Paris of seeing the brilliant results obtained by suggestion and persuasion in the treatment of hysteria. The leading neurologists employ these methods almost exclusively, reserving hypnotism for the very rare cases which do not respond to persuasion and suggestion. I was not at all favourably impressed by the methods used or the results obtained in the one clinique in Paris, which is still reserved for hypnotic treatment. No steps are taken to exclude the general public, and the room in which the patients are treated is full of a mixed crowd of medical men, students, patients and their friends, and men and women who are attracted by curiosity to the clinique, the programme of which is widely advertised in the shops and lay papers, as well as in the medical press. The professor begins by talking very eloquently of the results which can be obtained by hypnotism, and then gives practical demonstrations. One morning I saw three girls with functional aphonia hypnotised very easily one after the other, but not the smallest improvement was produced in their condition by suggestion during the hypnotic sleep. On the other hand, I very rarely saw a patient suffering from any form of hysteria leave one of the cliniques, in which suggestion and persuasion were alone used, before very considerable benefit had resulted. Often a painful electrical stimulus was used as an aid to mere verbal suggestion, but this was not at all an essential part of the treatment.

In the treatment of organic nervous diseases the French practice does not differ materially from the English. The one great advance of recent years is in the treatment of syringomyelia, which Professor Raymond, Charcot's successor at the Salpêtrière, now claims to be a completely curable disease. He finds that the X-rays have the power of causing the absorption of newly-formed neuroglia, and consequently the gliomatosis, which is the essential pathological process in syringomyelia, can be caused to disappear. I saw two undoubted cases of syringomyelia in Raymond's clinique which, after two years of treatment with the X-rays, were cured, and a third which was cured except for the persistence of a certain amount of atrophy in the muscles of the hands.

The unlimited wealth of the German hospitals, the result of the splendid system of compulsory insurance of the working-classes, and the great efforts made for supplying post-graduate teaching in every conceivable subject, make Germany an ideal country for a medical traveller in search of knowledge. The poverty of the French hospitals and the little interest taken in post-graduate education render a visit to Paris less satisfactory. But to anybody interested in neurology, after he has once learnt what cliniques to visit and the best days for each, a few weeks or a few months spent in Paris will afford an unrivalled opportunity of acquiring valuable information, and at the same time of passing a most enjoyable period in the most fascinating of cities.

A few Notes from the Index to the Medical Reports, 1907.

The figures *in brackets* are those from the 1906 Index, published in the Gazette a year ago.

	Number of Cases.	Number of Deaths.
Chronic alcoholism	54 (30)	11 (10)
Acute appendicitis (all cases)	158 (100)	21 (18)
First attack only	62 (28)	8 (?)
Appendicectomy performed	36 (33)	12 (4)
Laryngeal diphtheria (all cases)	33 (37)	11 (19)
Tracheotomy performed	27 (28)	11 (11)
Intubation performed	*5 (19)	3 (8)
* Four of these were subsequently tracheotomised.		
Hyperpyrexia	18 (17)	14 (11)
Acute intestinal obstruction (all cases)	34 (33)	18 (18)
Intussusception only	15 (13)	6 (8)
Treated by laparotomy	13 (11)	4 (6)
Empyema (all cases)	56	21
Resection of rib	47 (31)	13 (9)
Malignant endocarditis	12 (7)	11 (7)
Measles	50 (49)	13 (18)
Gastric ulcer perforation (all cases)	5 (8)	2 (2)
Laparatomy suture	4 (6)	2 (0)
Duodenal ulcer perforation (all cases)	2 (3)	1 (3)
Laparotomy suture	2 (3)	1 (3)
Typhoid fever	27 (23)	1 (1)
Uræmia	14 (13)	10 (11)
Diffuse peritonitis found by operation	51 (46)	35 (31)
Whooping cough with broncho-pneumonia	20 (11)	8 (4)
Lobar pneumonia (all cases)	216 (133)	28 (22)
Double pneumonia	11	6
Complications—		
Pericarditis	11 (3)	8 (2)
Meningitis	1	1
Nephritis	4	0
Albuminuria	17	3
Hyperpyrexia	4	1
Empyema	9	3
Abortion	2	0
Delirium	25	6
Acute endocarditis	3	2
Phthisis	83 (69)	26 (20)
Tuberculous meningitis	24 (20)	24 (20)

H. C. MANN.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Biennial Dinner, 1908.

Dear Mr. Editor, — There are one or two further points about the Biennial Dinner to which I shall be glad if you will allow me to refer in your columns.

There has already been a very satisfactory response to the circular issued last week, and in addition to the twenty-nine Vice-Chairmen whose names you recently announced, the following have already intimated their intention to be present. The years under which the names are arranged indicate the dates of qualification:—

'49—J. Bryant. '51—Sir C. Holman. '52—F. W. Pavy. '63—R. T. Nichols. '64—G. H. Savage. '65—R. Elphinstone. '67—C. Sangster. '68—C. Higgens. '69—A. Gillingham. '70—G. J. Congdon. '71—E. G. Younger, H. R. Kerr, J. H. Ewart. '75—St. C. B, Shadwell. '76—W. E. Dring. '77—L. W. Reynolds, C. K. Shaw, H. Davy. '78—R. J. Bryden. '79—W. Hale White, T. A. I. Howell. '80—G. Steele-Perkins. '81—P. Warner, P. H. Gardner, T. R. Atkinson, J. M. Owen, E. L. Adeney, L. E. Shaw. '82—S. Worthington, L. E. W. Stephens, G. A. Johnson, J. Fraser, L. A. Dunn. '83—J. H. Targett, W. R. Dakin. '84—S. H. Agar. '85—H. Lund, E. W. Goodall, F. R. B. Bisshopp. '86—E. C. Greenwood, F. Beard. '87—C. F. Routh. '89—R. W. Rouw. '90—J. Fawcett, T. G. Stevens. '91—D. W. Samways, J. Young, A. M. Daldy. '93—W. R. Grove, H. Cooper. '94—E. G. Little. '95—E R. Fothergill. '96—C. D. Edwards, R. H. Ashwin, M. Aston-Key. '97—M. Way, F. Fremantle. '98—H. L. Eason, E. W. S. Rowland. '99—J. L. Payne. '00—O. Marriott. '01—F. C. Wetherell. '02—H. K. Lacey. '03—H. W. Bethell. '04—E. W. Routley. '06—P. C. Litchfield. '07—M. M. Earle, G. W. Goodhart.

It would be a great assistance towards securing a large attendance if those who are proposing to be present would fill up the form of application and send it to me as soon as possible; any who may have mislaid the form will find a duplicate in the advertisement columns of this Gazette. I should like to publish a further list in the next issue of the Gazette, and nothing is so likely to decide a waverer to take the right course and come to the dinner as seeing in these lists the names of some old friends. I wish I could publish some of the many letters I am receiving from men who are prevented by age or illness from attending, and whose pleasant memories of many former Biennials encourage them to send us good wishes for the success of the forthcoming one.

The offers of hospitality by town members is greatly in excess of the requests for it by country members. If this is due to any diffidence on the part of country members, I should like to assure them that they need have no modesty in letting it be known that they are open to an invitation. Several town members say that they would like to put up two or three colleagues, and others, who are themselves prevented from dining, are yet anxious to act as host for the night.

From some inquiries I have received, it does not seem to have been clearly stated that members are able to obtain tickets for guests. This is so, and a considerable number of guests' tickets have been applied for.

It would be helpful if, in stating the names of the contemporaries whose presence is particularly requested, the initials could be added.—I am, yours sincerely,

LAURISTON E. SHAW, Hon. Sec.

27th May, 1908.

Odds and Ends of Interest.

Dear Sir,—When reading through my brief notes I felt there were one or two small points I should like to have added. It should, I think, have been stated that infants are not associated with pale thrombi in the small divisions of pulmonary artery. This is possibly owing to the fact that the pale thrombi are formed more slowly than the darker thrombi seen in association with infants. Yet, apparently, these pale thrombi may lead to rapid death. In a woman aged 43, found dead by the police, pale thrombi were present in the small divisions of the pulmonary artery in the lungs. The cause of their presence was probably septic infection from a chronic varicose ulcer of the leg.

Another point which occurred to me that may be worthy of mention is the occasional presence in the pancreas of other calcareous masses besides calculi. In three instances I have seen scattered calcareous patches in the pancreas, which appeared to have been the sequel of a disseminated suppurative pancreatitis from which the patient had recovered.

In closing, perhaps, Sir, you will permit me to tell your readers that the remarks in the foot-note which accompany my notes are a combination of editorial comments with my own. While I feel with you that every Guy's man must have photographs and notes of interesting cases, the publication of which would profit us all, I should not presume to say that anything of mine would "encourage" such publication. On the contrary, when one reads in print what one has written, the perusal is anything but stimulating in a good sense.—Yours very truly,

THEODORE FISHER.

May 18th, 1908.

Papers by Guy's Men.

The Goulstonian Lectures on the Influence of Pregnancy upon Certain Medical Diseases, and of Certain Medical Diseases upon Pregnancy. By Herbert French, M.A., M.D. Oxon., F.R.C.P. Lond. Lecture III. Illustrated.- *The Lancet*, 16th May, 1908.

An Address on Puerperal Eclampsia, with Special Reference to its Treatment with Nitro-Glycerine. By Justin M. McCarthy, M.D.—*British Medical Journal*, 23rd May, 1908.

Some Points Relative to Lesions of "The Hip."

Owing to improvements in methods of investigation, especially by means of the X-rays, many obscure lesions have been rendered clearer. In no region of the body is this statement more true than in connection with lesions of the hip.

Examination by X-rays forms, however, no infallible guide to conditions existing in this region, and for several reasons. First, the part is thickly covered with muscles. Secondly, the bones overlap each other to a great extent; and thirdly, a skiagraphic representation is liable to be a picture of parts which are, of necessity, foreshortened. Moreover, it is not always possible to obtain a competent skiagrapher.

In order that, at any rate, a reasonable, if not actually correct, diagnosis of lesions affecting the region of the hip may be made, it is necessary that the man who is attempting to make one should have a clear idea of the number of conditions which affect this region.

The conditions which lead to lesions in this neighbourhood may be thus classified:—

I. Inflammatory.
   1. Acute.
   2. Chronic.

II. Traumatic.

III. Congenital.

I. The Inflammatory affections:—

1. The Acute varieties.—Acute arthritis of the hip may be due rarely to an open wound, or may be associated with a pyæmic infection. Although, in many cases, doubtless an open operation is necessary in order that the purulent inflammatory products may be evacuated, in some cases, on the other hand, acute inflammation may only progress as far as the formation of granulation tissue, and the destruction of the articular cartilage, with resulting anchylosis of the joint. In other words, anchylosis may occur without the formation of pus.

Another result of acute arthritis of the hip is dislocation. The capsule becomes softened, and the head of the femur is dragged out of the cavity.

2. The chronic varieties.—These are usually due to the invasion of the parts by the tubercle bacillus. It is important to note, however, that some of the cases of chronic hip disease, with the formation of abscesses and sinuses, is not due to the invasion of the tubercle bacillus, but is really the result of an acute arthritis, with the eventual formation of a sequestrum. Such a case occurred about 6 years ago, at Shadwell Children's Hospital. A girl, aged about 12 years, had acute pain in the hip region and high temperature, with a furred tongue, and black rings round the eyes. The joint was very tender, but owing to the depth of the joint there was no swelling, œdema, or redness of the skin. A Liston's long splint was applied, and the urgent symptoms moderated. About three weeks after the onset, a large pelvic abscess formed, which was incised, and eventually a small sequestrum was removed through the sinus, which resulted from the opening of the abscess. If this case had been seen a month or six weeks after the onset, it might very reasonably have been diagnosed as tuberculous disease. The acute arthritis had terminated in a chronic condition.

Syphilis should not be forgotten as a possible cause of chronic disease in the region of the hip.

Osteoarthritis and Charcot's disease may also affect the hip-joint.

II. Traumatic affections.

These may be either dislocations or fractures. Messrs. Hamilton and Knight collected for me the cases which had occurred at Guy's in twelve years, of dislocation. They could only find about sixty, many of which were pathological. Although the books give very long and elaborate descriptions of dislocations of the hip-joint, such injuries are by no means common. In the year 1904, when I was surgical registrar, I did not see a single case of traumatic dislocation of the hip-joint.

Fractures in the region of the hip-joint.—Some years ago a man was admitted into Guy's Hospital. The head of his femur could be felt in the pelvis per rectum. The acetabulum had been smashed, and the head of the femur driven through it. Fracture of the acetabulum is, however, very rare. Fractures in this region resolve themselves into fractures of the femur. These may be classified as follows:—

1. Separated epiphysis.
2. Greenstick fracture of the neck of the femur.
3. Extracapsular fracture of the neck of the femur.
4. Intracapsular fracture.
5. Fracture of the shaft of the femur below the trochanters.

Of these conditions, the first and fifth need only concern us here.

Of sixteen cases of separated epiphysis occurring at Guy's Hospital, which I collected, fourteen cases occurred in males—a point in the diagnosis of the condition from congenital dislocation of the hip which as a rule occurs in females.

Another most interesting point in connection with the history of these cases is that, in many of them, the patient and his friends considered that there was but little wrong, and a serious condition was not suspected until the patient had been on his feet for some days, or had sustained another injury. In other words, nothing grave was suspected until the diaphysial fragment had slipped upwards on to the dorsum ilei.

A consideration of the anatomy of the upper end of the developing femur will afford a clue to this curious history.

The line of the epiphysis of the head lies at right angles to the pressure which passes downwards and outwards through the neck of the femur. I am not speaking now of the pressure, or back-thrust, which passes through the front of the head of the femur. The epiphysial line runs through the lower part of the articular surface of the head—that is, a small part of the head is formed

from the diaphysis of the shaft. In other words, the line of the epiphysis lies not only within the capsule, but also, for a considerable part, lies inside the acetabulum.

Separation of the epiphysis may occur, and the margin of the acetabulum still retain the fragments in position. Continual walking about after a separation, or another injury, dislocates the diaphysial fragment.

Fracture of the shaft of the femur may occur immediately below the trochanters. It is not an uncommon condition, but may be overlooked, as the fracture is usually transverse, and there may not be much displacement. The upper fragment is tilted outwards; the lower is, as a rule, also pulled outwards. The two fragments may be displaced forwards. The fracture is frequently due to direct violence. This fracture is mentioned here because there is reason to believe that, in some cases, it may be responsible for the condition known as coxa vara.

There are several types or classifications of coxa vara. It may apparently be due to several causes, *e.g.*:—

1. Separation of or injury to the epiphysis of the head of the femur.
2. Greenstick fracture of the neck of the femur.
3. Rickets.

It also occurs in adolescents without any obvious cause, or at any rate generally accepted cause. It is a curious fact, however, that although the growing ends of the long bones are active until the age of 20–25 years, the recognition of a possible rachitic affection in adolescents is generally regarded with disfavour.

The condition may be defined as one in which there is a diminution of the angle which the neck of the femur makes with the shaft. There is also a rotation backwards or forwards of the base of the neck, or the parts of the bone external to this portion of the femur. This rotation is usually backwards. There is a very good specimen in the museum of the College of Surgeons showing coxa vara secondary to an impacted intracapsular fracture of the neck of the femur.

Dr. Roper, of the Marylebone Infirmary, has kindly presented me with a specimen showing nearly the same condition. There is a specimen now in the dissecting room of coxa vara following upon extracapsular fracture. We must, therefore, recognize fractures of the neck of the femur as causes of coxa vara.

III. Congenital dislocation of the hip.

A few points may be mentioned in connection with this condition:—

1. It occurs most frequently in girls.
2. It frequently affects only one side.
3. The condition is not suspected until the child begins to walk.
4. There is a waddling gait.
5. There is marked lordosis.
6. The head of the femur can be felt in an unusual position, and can be moved about above the acetabulum.
7. The great trochanter is displaced above Nelaton's line, and moves upwards when pressure is applied to the foot.
8. The heel of the affected side is drawn up.
9. There are no signs of inflammation and little impairment of movement.

This is not the place in which to speak of treatment, but the efforts which are made to get the round head of the femur into the triangular acetabulum associated with congenital dislocation, with the capsule and ligamentum teres of the hip-joint intervening, are so frequently attended with such great success that he who considers only the anatomy of the parts must perforce admit himself beaten in giving an explanation of the cure.

A. R. T.

Inter-Hospital, Boxing, Fencing, and Gymnastic Competition.

The annual competition for the Inter-Hospital Cup took place in the gymnasium attached to the East London College, Bow Road, on Tuesday, May 19th, and ended in a victory for London, who scored 18 points; we were placed second, with 10 points, and University College third, with 8 points. The house was quite full, the partizans of the London Hospital being especially *en evidence*. We were pleased to see in the audience those keen followers of sport, Mr. Higgens and Dr. Allport. The chief interest was undoubtedly centred in the boxing, which throughout was of the most vigorous nature. As an aside, let us mention that several of the competitors looked suspiciously near their weights, and we should like to suggest that all weighing-in, in future, should take place at the ring-side, not at noon on the competition day. The judges for boxing were, Messrs. V. Barker, J. Cohen, J. Cooper, Eugene Corri, W. Giles, G. Sykes, R. C. Warnes, and E. T. Culver.

Mr. E. P. Minett (who, by the way, has been appointed medical officer for boxing at the Olympic Games), acted as M.C. Boxers were seconded by Charley Allen, Mat Smith, and Ted Mann.

Feather Weights (9st. and under).—1st round.—J. F. Richardson (London) beat E. Meinertyhagen (Bart.'s). An extremely fine fight. Richardson was distinctly the heavier man, and forcing the exchanges landed some hot shots on both head and body. The Bart.'s man, though indulging in as much out-fighting as he was able, received a rare gruelling during the first two rounds; staying well, however, he got home several times in the third round with a straight left, but was unable to make good his former losses, and Richardson won on points, after a keen contest.

R. M. King (Guy's) a bye.

2nd Round.—Richardson (London) beat King (Guy's). The finest fight of the evening. King was quite outweighted, but was easily the better boxer. Richardson took the aggressive and drove his opponent all round the ring, but he was swinging in a very wild fashion, with

the result that King got in his counters every time, using his left to great advantage. In the second round the London man tried to keep to in-fighting, but was beaten several times by King's footwork. In the final stage they both went at it hammer and tongs, King having Richardson on the ropes several times, but late in the round the London man's weight told, and he had King down with a blow on the mark. He was quickly up, however, and was scoring when time was called. The ring judges disagreeing, the referee awarded the match to Richardson, a decision meeting with rather a mixed reception.

Light Weights (10st. and under).—1st Round.—J. C. Woods (London) beat L. J. Kemp (Guy's). Woods had the advantage as regards both height and weight, and making the most of it he had Kemp all over the ring, having much the better of the earlier exchanges. Coming up the second time, both men were obviously feeling the effects of the pace, and the fighting was a bit wild, Kemp getting in several times, but with no beef behind it. In the last round he was fighting from start to finish, and made a much better show, countering well on several occasions, but was beaten on points after a fine fight.

C. E. Goddard (University) a bye.

2nd Round.—Woods beat Goddard. The University man must be considered unlucky to have been beaten, he was much the cleverer, but was beaten by weight. Early in the first round he got a left and right in on his opponent's head and nearly had him out, but in the last minute Woods, keeping the fighting closer, scored heavily. He nearly had Goddard out in the second round, hooking him to the floor, but he succeeded in keeping out of further danger till time. The last round was fought at a terrific pace, Goddard mixing it up well and having the better of some straight hitting, but the final decision was against him.

Middle Weights (11st. 4lb. and under).—E. Clouston (London) beat H. G. Rice (Guy's). The London man was half a head taller than his opponent. Honours were easy in the opening round, the fighting being a bit wild and a good deal of feeling being introduced into it. In the second, Rice forced matters at a great pace, landing heavily several times, but his great fault of boxing with a bent left was very apparent. He was scoring heavily, however, till an unlucky slip in the last minute let his opponent in. Clouston shook him up with a left on the side of the head, and never leaving him after was awarded the fight, after a close contest.

Clouston (London) beat Brown (Bart.'s). Clouston was the bigger man all round, and started hitting early, knocking Brown all round the ring; later he became rather wild, and Brown picked up several points by clean fighting. The fight degenerated to a mere slogging match, both men going all out, but Clouston's reach gave him the advantage and he won easily.

Heavies.—A. H. Crook (Guy's) beat S. J. A. Beale (London). There was a marked contrast between the two men, Crook being much more heavily built; but Beale had a distinct advantage in reach. The opening exchanges were fairly even, Crook getting in some heavy body blows, and Beale countering well on his opponent's head. Early in the second round Crook upset his man with an uppercut on the jaw, and using his right with great effect outed him before time was called.

Gymnastics.—Won by University. R. M. Walker and S. A. Owen (University), 197 points, 1; H. B. Parker and H. Neame (London), 194 points, 2; J. B. Bromley and M. Reader (Guy's), 184½ points, 3. J. B. Bromley had the highest aggregate, 104½ out of a possible 110. We were unfortunate in being unable to have the aid of Mr. G. H. Hunt, who was laid up with influenza. Our best thanks are due to Mr. M. Reader, who filled the breach at 24 hours' notice. Judge, Serjeant-Major Palmer (Aldershot).

Fencing.—Judges appointed by the Amateur Fencing Association. *Foils*—Guy Haycroft (Guy's), 1; S. H. Scott (London), 2; M. E. Vlasto (University), 3; V. D. C. Wakeford (Bart.'s), 4. *Epée*—M. E. Vlasto, 1; S. H. Scott, 2; Guy Haycraft, 3. *Sabres*—S. H. Scott, 1; Guy Haycraft, 2; V. D. C. Wakeford and M. E. Vlasto, 3.

Appointments.

Civil.

Ball, J. A., M.B. Lond., has been appointed Certifying Factory Surgeon for the Hoxne District, County of Suffolk.

Fremantle, F. E., M.B., M.Ch., F.R.C.S. Eng., D.P.H., has been appointed Medical Officer of Health to the Hertfordshire County Council.

Hertz, A. F., M.D. Oxon., M.R.C.P. Lond., has been appointed Lecturer in Materia Medica and Pharmacology at the University of Oxford.

Ward, P. H., L.R.C.P. Lond., M.R.C.S. Eng., has been appointed Medical Officer to The Ayrshire Mine, Lomagundi, South Rhodesia.

Naval.

Staff-Surgeon Percival M. May, R.N., has been appointed to the *Hannibal*, Surgeon H. G. T. Major, R.N., to the *President*, additional, for three months' course at West London Hospital, and Surgeon Richard Willan, R.N., to the *Donegal*.

Papers by Guy's Men.

A Method of Administering Solids in Cases of Gastrostomy. By A. Ernest Maylard, M.B., B.S. Lond.—*The Lancet*, 16th May, 1908.

A Lecture on Leukæmia. By Frederick Taylor, M.D. Lond., F.R.C.P.—*The Clinical Journal*, 27th May, 1908.

In Lighter Vein.

ANOTHER PONDEROUS ATTEMPT AT LEVITY!

One of the greatest difficulties which the young journalist has to overcome in his earlier days is lack of matter. This is a great pity, for two reasons, firstly, because the present tendency of journalism is decidedly degenerative; and, secondly, because the number of periodicals that appear before the public eye, weekly, monthly, and quarterly, is constantly on the increase. Of fortnightly journals we say nothing!

Another bunker the juvenile Baruch is sure to find very early in his career, is the art of affixing suitable titles to his efforts. He will always leave this to the last moment, in the hope of a kind of fourth *Star* "inspiration," and mostly winds up by tacking on at the eleventh hour a two-by-four one-horse attempt at some adjectival alliterative pun which brings tears even to the extra-dry eyes of the compositor. And, in parenthesis, journalists are not alone in this little difficulty. We would point to the playwrights—have they not their *first villagers* and *second citizens?* and even anatomists talk most familiarly of *unnamed arteries* and *innominate bones.*

In spite of such obstacles, we persist in holding on to our pen, candidly knowing nothing of our subject, for we are going to write about the Nursing Staff; and with grim determination we are selecting a title wherewith to label the pitiful tale of ignorance we have to tell. We had thought of tacking "ology" on the Greek for "nurse" (whatever it may be); but thoughts of indignant letters to the Editor from Miss Oxford bade us refrain. "Home Chat" suggests itself, but also Upper Tooting; "Home Notes" is pretty, but is rather personal; "Nurses I have met," neat, but hackneyed in the extreme; "Nurse-making and Nurse-taking," rests entirely with the Matron's office and the memory of Wilberforce: "From School to Strings," sounds like Mrs. L. T. Meade, and is unpleasantly suggestive of sudden death; "Mutton, thou once wert Lamb," besides being distinctly impolite, suggests the Antipodes and a crafty butcher contemplating a gross deception; "Sister Sarah Says——" could only be a parlour-game of the eighteenth century.

What need to go on? We have long since written all we know, and this is not an examination paper. We feel, too, that we have mixed metaphors in the most approved consecutive-fifth style: we have bunkered Baruch, we have put square wine into round bottles; let us leave a great subject to itself, let us make mole-hills of mountains. Let us remember the words:—

I look for sixty minutes' restful peace
On every Mon. and Wed. and Fri-day;
I'm thankful for a full two hours' increase
On Tues. and Thurs. and Sat.—that's my day!
To church, perhaps, I wend with added zest
Alternately on "Sun-o' my-Soul-days";
But blessed, ah! far blessed beyond the rest,
I really *am alive* on whole days.

STAR-ONE.

Guy's Hospital Ladies' Association.

OWING to the unavoidable absence of Viscountess Goschen, Mrs. Benyon presided at the Thirteenth Annual Meeting of the Guy's Hospital Ladies' Association, which was held in the Governors' Court Room on Thursday, May 21st. The following ladies supported Mrs. Benyon on the platform:—The Countess of Bective, the Countess of Kerry, Lady Perry, the Hon. Mrs. Molyneux, Mrs. Frederick Taylor, Mrs. Hale White, Mrs. Arbuthnot Lane, Mrs. Mason, Mrs. Merry, the Hon. Mrs. K. Campbell, Mrs. Cosmo Bonsor, and the local secretaries. About one hundred and fifty members were present.

In moving the adoption of the accounts, which was seconded by Mrs. Cosmo Bonsor, the Countess of Bective commented on the satisfactory financial position of the Association as evinced by its being able to make a donation of £300 this year to support six beds in the Maternity Ward.

The report of the committee was read by Mrs. Lauriston Shaw, the Hon. Secretary. The total number of members is now 1,331, an increase of over 100 during the past year. The main body had lost 22 members by resignation or death, five members by transference to local branches, whilst 20 new members had been added to the list. The committee much regretted the death of three of its oldest members—Lady Stevenson, Mrs. Bunting and Mrs. Huntley—whose generous help will be greatly missed.

Twenty-two branches were enumerated in the last report, and most of these had increased their membership. The West Norfolk branch had been amalgamated with the East Norfolk branch, and two new branches had been started, one at Tunbridge Wells and one at West Hertford. The committee reported with regret the resignation of Miss Willson, the energetic secretary of the Dulwich branch, who had done so much for the Association during the past five years. They took this opportunity of expressing their thanks to Miss Willson for her excellent work, and were pleased she had found a successor in Miss Carritt to fill the post she resigned. In addition, Mrs. Castle had organised at Stockwell the first branch composed entirely of junior members. Several of the branches now worked for definite wards,

and the garments were of excellent material and workmanship. The Lee and Blackheath branch still specialised in making boys' garments, always greatly needed, and the Clapham branch, among other things, contributed a large number of blouses and skirts for women.

The working parties in London had met regularly on alternate Wednesdays and Fridays during the winter. The committee desired to express their thanks to the ladies who so kindly cut out and supervised the work.

A very large number of garments were now contributed annually, many of them being used by patients while still in the wards of the hospital, and for this purpose special garments were made of definite patterns and materials. Others were used to help patients to go to convalescent homes. Many women refused the offer of a visit to one of these institutions because they had no suitable clothes to go in. The Ladies' Association might therefore be said to take a definite part in the complete restoration to health, which is the hospital's ultimate object.

The visiting of patients in the hospital under the auspices of the Association was still carried on with success.

The Junior Members' branch now numbered 221 members, of which number 90 belonged to the local branches. The total subscriptions of the junior members amounted to £14 7s., which helped to support a cot. Toys, books and children's garments had been sent for the children in the wards, and were much appreciated. They hoped to double the number of junior members by next year, so that their subscriptions would be sufficient to support a cot entirely.

The twelfth annual meeting was held at the hospital on May 30th, 1907, when, for the second time, the president of the Association, H.R.H. Princess Christian, took the chair, and about 170 members were present. After the meeting, Princess Christian inspected the work contributed during the year with much interest, and was entertained at tea by Mrs. Benyon and Mrs. Bonsor, with the vice-presidents, executive committee and local secretaries.

The committee were glad to see that the attendance at these annual meetings was becoming greater. They felt sure that the interest of members in the work was enhanced by seeing what was done in various directions, and by having an opportunity of inspecting the wards and other parts of the hospital.

At this annual meeting a special grant of £25 was voted for some need of the hospital, and on the advice of the Matron and Superintendent this sum was expended on the purchase of furniture for the balconies, now much used in the open-air treatment of many patients.

In acknowledging this gift, Sir Cooper Perry, the Superintendent of the hospital, had written—"The seats and tables are already greatly appreciated by the patients, and will be even more acceptable as the warm weather comes."

The committee had great pleasure in recommending that the sum of £300 should be given this year to the hospital for the support of six beds in the maternity ward. This ward is a small one, containing only eight beds, and it was hoped that in a few years the Association might be in a position to support all beds. This splendid result had been in a great measure achieved by the invaluable work of the local secretaries whose energy and enthusiasm were beyond all praise. To them the success of the Association was largely due, and their efforts were ably supported by the members generally.

Mrs. Benyon, in moving the adoption of the report, said she was sure everyone was glad to hear such a satisfactory report.

The Matron, in seconding the adoption of the report, said it gave her great pleasure to take this opportunity of thanking the members for their valuable help in providing garments for the patients. During the year, 684 garments had been given to patients leaving the hospital, and 489 were given out for use in the wards, making a total of 1,173 garments. The junior members, too, had sent a great number of toys, which gave great pleasure and delight to the little sick children.

The election of officers for the ensuing three years was proceeded with, and the present officers—Mrs. Benyon (Chairman), Mrs. Cosmo Bonsor (Vice-Chairman), Mrs. Pye-Smith (Treasurer), Mrs. Lauriston Shaw (Secretary), and Mrs. Ormond (Assistant Secretary)—were re-elected on the proposal of Mrs. Hale White, seconded by Mrs. Mason. The Countess of Kerry and Mrs. Charters Symonds were elected, on the proposal of Mrs. Arbuthnot Lane, seconded by Lady Perry, to fill the vacancies on the committee caused by the retirement of the Hon. Mrs. Molyneux and Miss Swift.

After the business was concluded, Mr. Cosmo Bonsor, the Treasurer of the hospital, gave a short address. He testified to the splendid achievements that were being wrought by the Ladies' Association, in that they were able to vote such a large sum for the support of beds in the hospital, as well as presents of balcony furniture, which were greatly appreciated, not only by the patients, but also by the medical staff, and by the sisters and nurses. He said they were also doing a great work by showing the interest that can be taken in a great charity such as Guy's. He gave a short account of the hospital, and spoke of its past financial difficulties. It was, he said, twenty-five years ago that he was appointed a Governor, and the hospital was then in a very critical position; they were losing funds, and the rentals from which it derived a great part of its income were being reduced year by year. In 1882, they had still further to reduce their tenants' rents, to close beds, and to devise some plan by which they could keep the great charity, o which they were the trustees, open. In 1895 (the year the Ladies' Association was started), the hospital was in a serious situation, the rents were reduced from £44,000 to £20,000; 150 beds had to be closed, and a charge of £1 1s. per week per bed was also being made in some of the wards so as to keep up a semblance of doing good

The hospital was more or less worn out, the floors were old, the furniture was out of date, and everything wanted replenishing. In that year, H.M. the King, as Prince of Wales, began to take an interest in Guy's Hospital. He took the chair at the dinner given at the Imperial Institute, and headed the appeal for funds for the re-endowment of the hospital, which has proved so successful and gained them so many new friends. Since that time they had reconstructed and added to the hospital, and had entirely refurnished it. The Nurses' Home had been built; they had their own laundry, water and electric light supply, and their own works department, all working within the few acres which contained Guy's Hospital. All this was wonderfully organised by Sir Cooper Perry, the superintendent, and it was a great satisfaction to know that, notwithstanding all these great additions and improvements, the hospital was being carried on most economically. He was glad to be able to state that the corporation is now entirely free from debt—for the first time for many years. He had been told that he ought not to admit such a thing, or people would not think it necessary to help them any further, but he could only say that he had just received a letter enclosing a cheque for £200, in which the donor said, "He was glad to see that they were out of debt, and he sent a cheque for a new debt." They were still in need of help from the public; they were now reconstructing and building the new out-patient department, through the munificence of an anonymous donor and the generous support of King Edward's Hospital Fund, and in the near future they hoped to be able to provide separate children's wards and to re-build Clinical House. Guy's, therefore, in spite of its present freedom from debt, was still in need of additional support to enable it to remain free from encumbrances and to carry on its work in an efficient manner. He thanked the members very much indeed for their generous help, and could only say he was sure that as long as the Ladies' Association existed, Guy's Hospital would also prosper.

The Countess of Bective, in proposing a very hearty vote of thanks to Mr. Cosmo Bonsor for coming to speak to them that afternoon, said she was sure, although Mr. Bonsor had said nothing about his own work as treasurer, everyone would realize that Guy's Hospital would not be in the happy position it was to-day if he had not taken such a keen interest in and done so much for the charity.

The Hon. Mrs. Molyneux seconded the proposal, which was carried unanimously.

At the conclusion of the meeting, the work done by members was inspected by those present, and after tea was partaken of, many visitors were shown over the Hospital and the Nurses' Home by the sisters.

CORRECTION.—In "Notes of a Roving Guy's Man" of last issue, dealing with the mortality of general peritonitis as treated at Hamburg, 9 per cent. should read 19 per cent.

Review.

The price of books submitted for review should in every case be stated.

Bodily Deformities. By the late E. J. Chance. Vol. I. Edited by John Poland.

This volume contains six lectures delivered by the late Mr. Chance at the City Orthopædic Hospital some fifty years ago. Orthopædic surgery has made such advances in this period that one would have expected the lectures to be hopelessly out of date. This is, however, by no means the case, chiefly because the cause of deformities is considered rather than their treatment. The lectures are well written, carefully thought out, and are illustrated by numerous cases which came under the notice of the author. The editor has omitted certain obsolete matter from the original lectures, and by means of numerous notes has recorded more recent conclusions. There is an interesting introduction, in which the development of Orthopædics as a branch of surgery is traced. The book is chiefly of historical interest.

Change of Address.

Mr. G. Wallace Badcock, L.D.S., from 55, Bromley Road, Catford, S.E., to 55a, Welbeck Street, W., and 13, Old Steine, Brighton.

Mr. Thomas Bryant, from 42, Norfolk Square, Hyde Park, W., to 19, Fitz-George Avenue, Kensington, W.

Dr. H. J. Gater, from Bexley House, Crayford, Kent, to 104, Grove Lane, Denmark Hill, S.E.

Mr. E. Climson Greenwood, from 19, St. John's Wood Park, N.W., to 1, Hanover House, Regent's Park, N.W. Telephone, 134 Paddington.

Dr. C. J. Morton, from Guy's Hospital to 8, Welbeck Street, W.

Dr. Percy H. Ward, from West Bank, East London, Cape Colony, to The Ayrshire Mine, Lomagundi, South Rhodesia.

From the Gazette's Special Pathologist.

T.R.A., CHADWELL HEATH.—Tubercle Bacilli are present in considerable numbers in this specimen of sputum.

W.L.W.M., HUDDERSFIELD.—This specimen presents great elongation of the papillæ of the mucous membrane of the tongue, with much epithelial thickening. At one place there is a small ulcerated surface covered by granulation tissue. We regard it as a condition of chronic glossitis, and find no evidence of malignant growth.

W.W.H., PEEBLES.—No Tubercle Bacilli are detected in this specimen of sputum, which contains but little muco-pus.

PATHOLOGIST.

Sport.—Cricket.

GUY'S v. UNIVERSITY COLLEGE HOSPITAL.

CUP TIE.—FIRST ROUND.

Played at Chiswick on May 19th. University batted first, and thanks to the good bowling of Charlton, four wickets for 18, and Kahlenberg, five wickets for 20, they were dismissed for 42, Tasker alone offering any resistance to our bowling. Guy's replied with 207 for two wickets, Birks 121 not out, and Medlock 61, played excellent cricket, Birks' century including one 6, one 5, and nineteen 4's. On going in again, University were dismissed for 75 runs, leaving us very easy winners. We have not to meet the winners of King's v. Bart.'s match. If we are to obtain the Cup all the large Hospitals have to be met, and if our team will only practise there is no reason why we should not come out "on top." Scores:

UNIVERSITY COLLEGE.

	1st Innings.		2nd Innings.	
H. L. Tasker, b Charlton	19	b Clapperton		2
R. Woodsend, c sub, b Kahlenberg	5	not out		15
R. Jones, b Kahlenberg	0	c Charlton, b Chase ...		0
J. Bailey, b Charlton ...	6	b Chase...		0
A. Henderson, run out ...	0	b Tooth		5
W. Bowen, b Kahlenberg	0	b Tooth		0
A. L. Robison, b Charlton	1	c Montgomery, b Tooth		0
W. Elliott, b Charlton ...	0	c Charlton, b Chase ...		3
C. Rogerson, not out ...	0	b Chase...		11
J. Benjafield, c Montgomery, b Kahlenberg	0	run out...		8
N. K. Foster, b Kahlenberg	2	run out...		25
Extras	9	Extras		6
Total	42	Total		75

GUY'S.

M. M. Munden, c Bowen, b Bailey	4
C. H. Medlock, c Tasker, b Henderson	61
A. H. Birks, not out	121
F. D. Saner, not out	11
Extras	10
Total for 2 wickets	*207

*Innings declared closed.

J. H. Clapperton, H. Lee, R. G. Chase, P. C. Charlton, R. Montgomery, F. Tooth, F. Kahlerberg, did not bat.

GUY'S v. HAMPSTEAD.

Played at Honor Oak Park on Wednesday, May 20th, and ended in a win for the Hospital by 82 runs. Guy's batted first and scored 247. Montgomery played a very fine innings, and was unfortunate in missing his century. Hampstead were dismissed for 165, and of these Hickson got 100. The Hospital fielding was very bad throughout, most members of the team dropping simple catches. Charlton bowled well, taking four wickets for 24 runs. Score:— Guy's, 247. Hampstead, 165.

GUY'S v. REIGATE,

Played at Reigate on Saturday, May 23rd, and ended in a win for the Hospital by 40 runs. Guy's batted first and were all out for 136. Montgomery, 31, and Lee, 29, batted well. By dismissing Reigate for 96 we did very well; their low score was due to our good fielding, several good catches being taken, Lee's being an exceptionally fine one. We were cheered to victory in this match by our president, Sir Alfred Fripp. Score:—

Guy's, 136. Reigate, 96.

Golf.

The First Monthly Medal Competition (under handicap) took place on Wednesday, May 27th, at Chingford. This was a 'Stroke' Competition, for which a card for one round of 18 holes had to be returned. Eighteen entries were received, and 7 cards were returned. In conjunction with this, there was also an Optional 1/- Sweepstake, for which there were 17 entries. There were also two prizes. First—a dozen balls (Waverley), presented by Willie Park, for the best 'net' score for the full round. Second—a golf club, presented by Dr. Cameron, for the best 'net' score for the last 9 holes, no one player to receive both prizes.

The Sweepstake (17/-) was divided:—

12/- for the best 'net' score.

5/- " " 2nd " "

Mr. H. B. Carlyll was the winner of Medal, Balls, and Sweepstake. Mr. H. L. Duke won the 'club,' and 2nd prize in Sweepstake.

Lawn Tennis.

1ST VI. v. CAIUS COLLEGE, CAMBRIDGE.

This match took place at Cambridge on May 23rd, and resulted in a win for Caius by 5 matches to 4. Although we lost, there was very little to choose between the teams. If anything, we were the better, and ought to have won.

H. Chapple and H. Sharpe won their three rounds, F. J. Cutler and R. Curle only winning one of their matches, whilst M. M. Earle and G. H. Hunt were not successful in any.

Rifle Association.

The first Armitage Cup shoot took place at Bisley on Wednesday, May 13th, the shooting of all teams being affected by a succession of violent thunderstorms.

Guy's 460; St. Thomas's 420; Bart.'s did not finish; St. Mary's have not sent in result.

Swimming Club.

Water Polo.

GUY'S v. THE OTTER S.C.

On Tuesday, May 26th, at Westminster Baths. The Otter had a strong side out, and beat us by 4 goals to 0. Their goals were scored by Beale and Dixon. All our side played well, but our opponents were faster and better trained.

BOOKS RECEIVED.—Bennett's Materia Medica and Pharmacy; Kenwood's Public Health Laboratory Work; Taylor's Medicine, 8th edition; Keith's Cancer; Walker's Dermatology; Martin's Ambulance Questions; Proceedings of the Royal Society of Medicine, No. 6; Lloyd's Hay Fever and Asthma; Schmidt's Jahrbucher and Virchov's Archiv. to date; May and Worth's Diseases of the Eye, 2nd edition; Wheeler's Medicine and Therapeutics.

Deaths.

DOBSON.—On May 24th, at Knott End, Windermere, Thomas Henry Dobson, M.D. Lond., of Myln Garth, Windermere, aged 31 years.

MAY.—On May 21st, at 39, Oxford Gardens, W., Edward Henry May, M.R.C.S., aged 73 years, late of 68, Pentonville Road, N.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

June.

Sat. 13. 1st XI. v. The Past (Home).
Cricket Dinner in the evening at the College.

Mon. 15. Special Clinical Lecture by Mr. Steward at 1.15 p.m. (Laryngology).
Cambridge 1st and 2nd Exams. Part I. of 3rd commences.

Wed. 17. Inter-Hospital Athletic Meeting (Stamford Bridge).

Thur. 18. Mr. Golding-Bird and Sir Alfred Fripp's Take-in commences (Messrs. Flower and Cook).
1st XI. v. Bickley and Bromley (Away).

Fri. 19. Water Polo v. Grafton (Home).

Sat. 20. 1st XI. v. Lessness Park (Home).
2nd XI. v. Norbury "A" (Away).

Mon. 22. Special Clinical Lecture by Mr. Iredell at 1.15 p.m. (Actinotherapeutics).
Swimming Club Sports, at 8 p.m.

Wed. 24. 1st XI. v. Hampstead (Away).
2nd XI. v. Spencer "A" (Away).

Thur. 25. Messrs. Symonds and Steward's Take-in commences (Messrs. Stebbings & Henderson).

Fri. 26. Lecture by Prof. Raymond in Physiology Theatre at 11 a.m.

Death of a Governor.

THE passing away of Mr. M. TREVELYAN MARTIN leaves a serious gap in the list of Governors.

Though connected only for the past nine years with Guy's, he had, during that time, secured for himself an influential position amongst his colleagues.

From the first he took a keen and liberal interest in the fortunes of the Hospital, and was always eager to promote the comfort and welfare of patients and officials.

In early days, at Rugby and Cambridge, he proved himself a great athlete, but in later years his health was not robust, and his sudden death has caused sincere regret to a host of friends, by whom he was much respected and beloved.

Passim.

ALL Guy's men, and those interested in the Hospital, will read with pleasure the Annual Report for the Year 1907. At the close of the year all loans had been discharged, and the Hospital—to a great extent owing to the wills of Mr. Alfred Beit and Mr. Samuel Lewis—stood free from debt. This means that the Governors have completed and paid for practically all the works included in the 1901 Appeal, and re-stated in the Appeal of 1905, and that now they can concentrate all their efforts on the augmentation of the regular income and the provision of the new Out-patient department, separate Wards for Children, and the rebuilding of Clinical. The achievement of clearing the Hospital of debt is a monumental one, and is one which will mark our respected Treasurer, Mr. Cosmo Bonsor, as the greatest who has ever held that much-honoured post. In Lord Revelstoke and Mr. Cosmo Bonsor we have two men who are "forces" whose financial genius is a byword in England. That we should have the benefit of it is a thing beyond gratitude; and, between ourselves, of envy, for comments

on the great achievements of the Finance Committee from other hospitals breathe a spirit of no little desire.

The Statistical Tables, some of which we have already published, show the enormous amount of work carried out by the various departments. For example, the average number of pieces washed weekly on the Hospital premises is 21 856, whilst the net amount of the Hospital's annual washing bill is £1,746 18s. 8d. We notice that the figures in the Tables are presented in a different form to hitherto. They are now published in accordance with the uniform system of hospital accounts as adopted by the various funds. They are more compact and more wieldy.

We are about to have demonstrated to us that *l'entente cordiale médicale* is something tangible, for Sir Dyce Duckworth's recent lecture before French medical men in Paris is to be followed by a lecture to be delivered at the Royal College of Physicians by Dr. Fulgence Raymond, the Professor of Neurology at the famous Salpêtrière Hospital, Paris. The subject of the lecture will be "Les Maladies dites Familiales," and is timed to take place on Monday, June 22nd, at five o'clock. Professor Raymond is coming to England to receive the honorary degree of Doctor of Science from the University of Oxford.

We, at Guy's, are to be congratulated, for this famous French savant, the successor of Charcot at the Salpêtrière, has kindly consented to hold a clinique at 11 a.m. on Friday, June 26th, in the Physiology Theatre. He will demonstrate two or three nervous cases, in order to illustrate the methods he employs at his famous Tuesday lectures at the Salpêtrière. Every Guy's man, past and present, who is free on the morning of the 26th, should make a point of attending and giving a right royal welcome to our distinguished visitor. Though they may not understand French, they will, we feel certain, be able to appreciate Professor Raymond's charming methods of giving a clinique.

We have received a letter from a correspondent who worked under the late Dr. T. H. B. Dobson, whose sad death, at the early age of 31, we announced in our last issue. He writes:—"Many Guy's men will have read the news of the death of Dr. T. H. B. Dobson with the deepest sorrow. He was President of the Residents in 1902, and as one who had the privilege of being a ward clerk under him when he was Sir Cooper Perry's house-physician, I can testify to his great popularity among his juniors as well as his contemporaries. Whilst still a Resident, he made some interesting observations on the value of atropine in the treatment of persistent hiccup, and a remarkable paper recently published by him in the *British Medical Journal* on Migraine, from which he himself was apt to suffer, showed that, in spite of the exigencies of a busy country practice, he was yet able to make valuable scientific observations. His loss will be long felt by his many friends, both in Windermere and at Guy's."

At the forthcoming election to fill the vacancies on the Council of the Royal College of Surgeons, Guy's will be represented by two candidates, Mr. Arbuthnot Lane and Mr. George Eastes. We need hardly point out that these candidatures are in no way antagonistic, for Mr. Eastes represents the General Practitioners, whilst Mr. Lane is standing as a Consulting Surgeon and a member of the Staff of Guy's. Everyone who can help should do so by bringing the claims of these two worthy candidates before any Fellows with whom they may be acquainted. To old Guy's men holding the Diploma of F.R.C.S. Eng., this note should be unnecessary, but we trust also that they will use their utmost endeavours to ensure that the two Guy's men will occupy high positions on the poll. The Editor will be pleased to hear of any promises of support, as it will greatly convenience both candidates in their electioneering work.

The ideal country practitioner has often been the theme of many pretty similes and epithets, but we cannot refrain from reprinting what Dr. N. A. Powell, in an address to the University of Toronto Medical Society, thinks should be

the qualities of this hard-worked and extremely useful member of the community:—

> "To be perfect," he says, "an ideal doctor, would need to have the wisdom of Solomon, the patience of Job, the strength of Samson, the bravery of Joshua, the eloquence of Paul, the meekness of Moses, the faithfulness of Abraham, the charity of Dorcas, and the executive ability of Jezebel. He would have to hunt like Nimrod, fish like Peter, climb like Zaccheus, and drive like Jehu. He would have to keep clear of the gout of Asa, the melancholia of Saul, the gastric infelicity of Timothy, and would still fall short of perfection if he had not the tireless perseverance of the devil himself."

Verily, a marvellous creature!

WE heartily congratulate the Rev. Ambrose Lethbridge on his appointment to the Vicarage of St. Margaret's, Leicester: yet it is with mixed feelings, for we will miss him sadly. Nurses, students and patients, one and all, have found him one of the best of chaplains and fellows. His tact, discretion, ability and personal charm have endeared him to all who have come into contact with him. In the wards the patients have awaited and looked forward to his visits in no half-hearted way, whilst many of the men will miss a personal friend whose cheery "good morning," and readiness for a round of golf, were as refreshing as a summer breeze. He came to us in April, 1906, and since that time has fulfilled his duties in the capable manner that his new appointment suggests. We voice the sentiments of nurses, patients and students when we wish him the best of health, happiness and prosperity in his new sphere.

THE Annual Sports on Wednesday last were a huge success, and reflect much credit on their organisers, Messrs. Browning and Oram. The attendance was above the average, and the number of the fair sex present showed that nurses, sisters, cousins, etc., are keen sportswomen. The ground looked excellent, and great credit is due to the groundsman, Harris. The fields were small, but what they lacked in quantity they made up in quality, and our chances of winning the trophy back from London are cheery. The Inter-Hospital Sports are to be held next Wednesday at Stamford Bridge, and we hope that many men will take this opportunity of enjoying a good day's sport. Mr. S. H. Browning was again the winner of the Lucas Challenge Cup, his record being quite remarkable, gaining four firsts, one second, and one third. The Employee's Race resulted in a popular win for Harris, who, in spite of giving away many years to the rest of the competitors, ran away from his field completely. Mrs. F. J. Steward presented the prizes. Dr. Fawcett, the new President, thanked this lady for her kindness, and voiced the sentiments of all present when he remarked how pleased he was to see Mr. Clement Lucas there. Mr. Lucas, in returning thanks, stated that though no longer officially attached to the Club, his interests in hospital athletics were as keen as ever.

WE wish to draw the attention of our readers to the notice of the Biennial Dinner, on a later page. The list of those who have promised to attend will contain many of your friends' names. Do not postpone applying for tickets, but do so at once, and so facilitate arrangements. It is an occasion which should not be missed, and it should be a powerful excuse which will deter a Guy's man from attending.

THE Annual Swimming Sports are to be held on Monday, June 22nd, at 8 p.m., at the Southwark Baths. The programme is a most attractive one. Miss Ada Lewin, the well-known lady diver, has promised to give a display. There will also be an exhibition of diving by Mr. Gordon Clarke (amateur champion) and friends. The polo match, Past v. Present, should be productive of good sport, whilst the entries for the other events—including a ladies' race—are excellent, and each race will be well contested. Lady Constance Stewart Richardson has kindly consented not only to award the prizes to the successful competitors, but also to give an aquatic display herself. This popular and talented member of the Bath Club is too well known a performer in the water to need any praise from our pen, and we trust that her kindness in coming down will receive adequate recompense by performing before a crowded audience; that it will be an appreciative one we have no doubt.

THE Water Polo Team is strong this year, and should have a very successful season. So far, though the team has seldom been at full strength, it has given a good account of itself. We congratulate Messrs. T. Clark and H. Glover on their appointments to the Captaincy and Secretaryship respectively of the United Hospitals Club. This first-class combination should, on paper, be almost invulnerable.

THE Annual General Meeting of the Football Clubs will be held on Thursday, June 18th, at 4.15 p.m., in the Anatomy Theatre. Business: To Elect Officers for Season 1908–09. All men should turn up.

As we are going to press we have received the list of the new appointments. Our congratulations to Messrs Rippmann and Layton on their appointments to the posts of Medical and Surgical Registrars respectively.

Appointments.

The following appointments have been made by the Treasurer on the recommendation of a Staff Meeting:—

A Lecturer on Surgery.—Sir Alfred Fripp.

Joint Lecturer on Anatomy.—Mr. Fagge.

Demonstrators of Practical Dentistry.—Messrs. E. B. Dowsett, F. J. Pearce, H. B. Aubrey, H. C. Malleson.

Demonstrator of Operative Dentistry.—Mr. H. Chapman.

Curator of the Dental Museum.—Mr. E. B. Dowsett.

Anæsthetists to the Dental School.—Messrs. W. M. Mollison, A. R. Thompson.

Anæsthetists to the Hospital.—Messrs. P. P. Laidlaw, W. M. Mollison, A. R. Thompson, E. C. Hughes.

Demonstrator of Pharmacology.—Mr. P. P. Laidlaw.

Demonstrator of Chemistry and Organic Chemistry.—Mr. W. C. Ball.

Demonstrator of Chemistry and Physics.—Mr. R. W. Merriman.

Clinical Analyst.—Mr. J. H. Ryffel.

Demonstrators of Anatomy.—Messrs. A. R. Thompson, W. M. Mollison, E. C. Hughes.

Surgical Registrar.—Mr. T. B. Layton.

Demonstrator of Operative Surgery.—Mr. W. M. Mollison.

Medical Registrar.—Mr. C. H. Rippmann.

Change of Address.

Dr. E. J. F. Hardenberg, from Annesley, Fairlop Road, Leytonstone, N.E., to Glendale, Station Road, Chingford, N.E.

Dr. H. V. Mitchell, from Victoria Road, Tamworth, to Beechcroft, Tamworth.

Mr. H. P. Tait, L.D.S., from Guy's Hospital, to Ovenden House, Tenterden, Kent.

Guy's Hospital Biennial Dinner.

THE following Guy's men have already intimated their intention to be present at the Biennial Dinner, which will be held at the Hotel Cecil, on Wednesday, July 8th, under the chairmanship of Mr. Charters Symonds. The names are arranged approximately in order of the date of qualification:—

T. Bryant, Sir C. Holman, F. W. Pavy, J. Rand, J. Tanner, A. Roper, H. A. Martin, P. Minns, Sir T. Stevenson, R. T. Nichols, P. H. Pye-Smith, F. Manser, G. H. Savage, G. Eastes, R. Elphinstone, J. R. Bosworth, C. Sangster, B. N. Dalton, C. Higgens, C. T. Brookhouse, R. Bowen Hogg, T. S. Townsend, W. B. Taylor, F. Durham, G. W. Shipman, A. Gillingham, G. J. Congdon, E. G. Younger, H. R. Ker, J. H. Ewart, W. A. Brailey, C. H. Golding-Bird, W. J. Tyson, St. C. B. Shadwell, C. J. Symonds, T. Brown, W. G. Dring, J. Mackern. L. W. Reynolds, C. K. Shaw, H. Davy, W. L. Chubb, J. T. Gardner, R. J. Bryden, W. Hale White, T. A. I. Howell, G. Steele-Perkins, J. F. Briscoe, C. J. Harper, H. Blatherwick, P. Warner, P. H. Gardner, T. R. Atkinson, J. M. Owen, E. L. Adeney, S. Worthington, L. E. W. Stephens, G. A. Johnson, J. A. Fraser, L. A. Dunn, H. P. Berry, R. Cuff, J. H. Targett, L. E. Shaw, W. R. Dakin, A. J. Dalton, C. D. Muspratt, A. J. Carter, S. H. Agar, R. W. Brogden, H. E. Counsell, G. F. Hugill, S. Wacher, H. Lund, H. Hore, A. E. Price, E. W. Goodall, F. R. B. Bisshopp, F. Beard, E. C. Greenwood, F. F. Burghard, C. F. Routh, P. N. Randall, G. Black, H. M. Brownfield, W. C. Swayne, H. J. Holman, R. W. Rouw, W. J. Scott, T. G. Stevens, J. Fawcett, F. Vicars, G. W. B. Featherstone, B. W. Hogarth, J. W. F. Jewell, A. M. Daldy, J. Young, D. W. Samways, W. E. S. Cobb, C. G. Roberts, F. C. Young, E. E. B. Landon, W. Carling, J. D. Thomas, W. Bligh, J. J. E. Biggs, H. Cooper, W. R. Grove, A. Shillitoe, J. Eyre, A. Allport, E. G. Little, A. P. Allan, F. J. Steward, H. A. Duffett, E. T. Shorland, E. R. Fothergill, E. Fisk, W. Tyson, C. D. Edwards, G. B. Muriel, R. H. Ashwin, C. H. Fagge, M. Aston Key, J. H. Busteed, A. J. Cleveland, F. Fremantle, M. Way, C. E. Michael, P. Turner, G. N. Mottram, E. W. S. Rowland, H. L. Eason, R. H. J. Swan, W. J. Henson, W. R. Cazenove, A. A. Miller, J. L. Payne, T. P. Thomas, O. Marriott, K. V. Trubshaw, F. C. Wetherell, R. Thompson, F. D. S. Jackson, H. K. Lacey, B. Glendining, H. W. Bethell, A. R. Brailey, E. W. Routley, H. M. Woodward, E. C. Hughes, W. M. Mollison, A. F. Hertz, E. W. Sheaf, H. C. Cameron, H. D. Wyatt, P. C. Litchfield, C. F. Fothergill, E. L. Norton, G. W. Goodhart, M. M. Earle.

All applications that seats may be reserved should be sent to the Hon. Secretary, Dr. Lauriston Shaw, 64, Harley Street, W.

Notes from Dr. Hertz's Demonstrations of Nervous Cases.

CASE I.

Angina Cruris (Intermittent Claudication).—Discussing the case, Dr. Hertz said:—"This man, who is 64 years old, is suffering from a very rare condition, and one of considerable interest. Four years ago he began to notice a curious difficulty in walking, which, he says, came on after influenza. He was able to walk only a short distance, perhaps a mile, before he suddenly was seized with cramp in his legs, and had to rest a few minutes before he could continue. Last August he became worse, and could walk only a quarter of a mile without an attack of cramp. His condition is that known as Intermittent Lameness, or Claudication: a better name is Angina Cruris.

"He has very thick hard arteries, though his radial artery, curiously enough, is quite normal. One can feel hardly any pulsation in his femoral artery, or in the antecubital fossa. His dorsalis pedis artery feels like a piece of wire. At one time it was impossible to feel pulsation in it, but at present there is a little to be felt. He has thus got arterio-sclerosis of the vessels of his legs. When he is at rest the amount of blood which is supplied through the vessels is sufficient; when exercise is taken the amount of blood required by the muscles becomes enormously increased. In cases such as this, owing to the condition of the vessels, an insufficient supply of blood results, and the patient gets cramp. He rests for a time, and the supply of blood becomes again temporarily sufficient. In angina pectoris you have a similar condition in the coronary vessels. If the heart has increased work to do, there is an insufficient blood-supply to the heart, and it refuses to work, an attack of angina pectoris resulting. The two conditions are thus analogous."

Treatment.—This aims to produce dilatation of the abnormal vessels. Since August last he has been treated with nitroglycerin and potassium iodide. The result has been good. He can now walk a mile without cramp; he has, however, to stop at the end of that distance for five-minutes' rest, in order to avoid an attack.

CASE II.

Cerebral Thrombosis associated with latent Tabes Dorsalis.—This patient, a man of 31, came to the hospital on account of weakness of his left arm and leg, which had come on, in the course of a few hours, four days previously. There had been no unconsciousness. Two days later he was aphasic for a short period, but there was no paralysis of the right side, although he was a right-handed man. When examined, he was found to have a definite organic hemiplegia. The reasons for considering it organic were: his elbow-, wrist-jerks, and knee-jerk on the left side were brisker than on the right side, but he had no ankle-clonus. He had an extensor plantar reflex on the left side. On getting the patient to lie at full length on the floor, with arms folded and legs apart, and making him rise to a sitting posture, the left leg was observed to rise higher than the right. This sign is due to Babinski, and is characteristic of organic lesions; for in functional hemiplegia the paralysed leg remains lower than the other.

Dr. Hertz said: "We have here a case of definite organic hemiplegia. There is no heart lesion, so an embolus can be excluded. It is quite unusual in a man of thirty-one to get cerebral hæmorrhage, and, moreover, he had no unconsciousness at the onset, nor albuminuria, or other sign of granular kidney. The only thing left is thrombosis, the cause of which, in a man of this age, would be probably syphilitic endarteritis. So far the case is fairly straightforward. But we must explain the fact that his pupils are unequal, the left being much larger than the right. He says this has been so for years. Neither pupil reacts to light, but both do to accommodation, so that these are definite Argyll-Robertson pupils. This is a sign of syphilitic nervous disease, including tabes dorsalis, and general paralysis of the insane. The eye condition, therefore, confirms the diagnosis of the syphilitic origin of the thrombosis. But there are some other unusual features about the hemiplegia. The knee-jerk is not exaggerated to the same extent as might be expected, and there is no ankle-clonus. In fact, *both tendo-Achillis jerks are absent.* Absence of the tendo-Achillis jerks, without the knee-jerks present, and without other symptoms, is generally due to the presence of a latent neuritis from alcohol or diabetes, or to early tabes dorsalis. For in very early cases of tabes you find the knee-jerks still present, but no tendo-Achillis jerks. The association of this sign with the Argyll-Robertson pupil confirms the diagnosis of early tabes. The patient has had no bladder trouble, no inco-ordination or ataxic gait, so we have only signs to go on; we have no symptoms, beyond what may have been shooting pains, for some time ago he had something which was called sciatica, the pain in his leg being of a shooting character. Thus, if the patient had not had his attack of hemiplegia, due to syphilitic cerebral endarteritis, we should not have had a chance of diagnosing his early tabes, perhaps for several months, or even years. He has been treated with mercury and potassium iodide. There has been gradual improvement in the hemiplegia, which may probably be due to the treatment, as its effect will be to make the syphilitic endarteritis clear up. It is difficult to get hold of very early cases of tabes, in which alone anti-syphilitic treatment may possibly do some good. In such a case as this, it is possible that the progress of the disease may be arrested, and it is even conceivable that the extent of the lesion in the spinal cord might be diminished. There is no history of venereal disease in this case, but there are two points in favour of attributing it to syphilis—(1) the thrombosis occurring in a man of 31, and (2) the fact that tabes is probably always due to syphilitic infection."

F. J. W.

Junior Guyite Club.

THE twenty-eighth dinner of the above club was held at the Frascati Restaurant on the 14th May, and was attended by the following twenty-five members of the club. It proved to be a most enjoyable reunion:—President, Percy Warner; Vice-president, Lockhard E. W. Stephens; E. C. Beale, F. R. B. Bisshopp, H. Blatherwick, L. Burroughs, T. Brown, L. A. Dunn, H. L. Eason, J. Fawcett, Herbert French, A. Green, P. Horrocks, T. D. Lester, A. W. Ormond, R. R. W. Oram, G. N. Pitt, A. E. Price, J. A. P. Price, P. N. Randall, R. M. H. Randell, G. H. Rodman, C. Sangster, A. Shillitoe, and Jas. A. Fraser (hon. sec.).

The President for 1909 is Lockhart E. W. Stephens, and the Vice-president, Chas. Sangster.

The following new members were duly proposed and elected:—A. Allport, J. B. Cruickshank, Wm. Sampson-Handley, A. F. Hertz, E. C. Host, Jas. G. Phillips, and Sidney Mathews.

The next dinner will be held at the Frascati Restaurant on the second Thursday in May, 1909.

'91 Fraternity Dinner.

THE seventeenth dinner of the Guy's '91 Fraternity was held at the Trocadero on May 7th. There were present:—J. W. F. Jewell (*in the chair*), C. F. Routh, F. M. Turner, A. E. Norburn, J. M. Thorne, J. S. Richards, J. D. Cruickshank, J. Robertson, N. Clowes, J. Lloyd Roberts, H. V. Hickman, C. Spurrell, John Fawcett, J. W. Russell, F. G. Swayne, T. G. Stevens, H. L. E. Wilks, Astley Roberts, W. C. Swayne, G. Bellingham Smith, R. G. Poole Lansdown, and Norton B. Clowes.

A most enjoyable evening was spent, and the usual toasts responded to with enthusiasm.

Guy's Colonial Club.

Annual Dinner.

THE Annual Dinner of the Guy's Colonial Club was held in the Connaught Rooms of the Trocadero last Thursday evening. Though the attendance was not large, a most enjoyable evening was spent. Mr. Charters Symonds filled the chair, with his usual affability. An excellent menu having been done full justice to, and the loyal toasts drunk, the Rev. Dr. Huns, chaplain to the King's Own Colonials, in proposing Guy's, entertained us with an excellent speech, which breathed Imperialism, and dealt with the abstract side of hospitals. He tempered it with some much-appreciated and well-told "stories." This toast was drunk with great enthusiasm. Mr. F. W. Young, in a very good maiden effort, proposed the Colonies; to this Mr. Ledlie responded. The Visitors, proposed by Mr. Grice, was replied to by Dr. Bowen-Jones, whose stories of days under Dr. Galabin, as Charity, were received with much laughter. Mr. Mandel, in a rambling *mélange* of fact and fiction, replied to the toast proposed by Dr. Huns. Mr. Symonds traced the history of the Club back to its infancy, in a speech which was full of good advice and encouragement, and coupled with the toast of the Club the name of Mr. Stringer, who responded for the Hon. Secretaries. During the evening Mr. F. Endean gave us some of his capital songs and incomparable imitations, the ever-green, cleft-palate version of Kissing Cup's Race being much in favour. Mr. F. Brown played a pianoforte solo, but the *pièce de resistance* of the evening was a Maori war-dance, by Messrs. Endean and Monaghan (the administration of the Trocadero are still wondering whether it was a seismographical disturbance or merely a thunderstorm).

It is to be regretted that not more Colonials attend this annual function, for it is a most enjoyable reunion. The Secretaries for the oncoming year are Messrs. Stringer and K. Hoby.

Case for Diagnosis.

John R., æt. 38, was admitted to John ward on May 19th for pain in the legs and loss of power in the legs and arms.

Previous history.—He had syphilis in India fifteen years ago, and was thoroughly treated with mercury and potassium iodide. His work at present is in the dye department of a tan yard; this entails the constant handling of arsenic and aniline dyes. For the last three weeks he has suffered from insomnia, and he has noticed that he is unable to write correctly—even copying being often quite incorrectly done. His memory also has been getting progressively worse. He is a moderate drinker and a heavy smoker.

History of present condition.—On the day of admission he noticed on getting up that his feet were painful, and during the day the pain spread up the legs as far as the hips. The arms became weak, and he had some respiratory difficulty and attacks of faintness. Temperature 98°.

An examination of the nervous system revealed the following points:—

Acute hyperæsthesia of both legs—even the weight of the bedclothes being painful.
Paresis of both arms and legs; no spasticity.
Plantar reflex absent on both sides.
Ankle clonus and increased knee-jerks on both sides.
Considerable tremor of the hands, and a marked intention tremor.
Abdominal and cremasteric reflexes present.
Two painful areas along the spine, one in the lumbar and the other in the cervical region; no herpes zoster.
No facial paralysis, but the tongue is protruded to the left, and cannot be moved to the right side.

Eyes.—

Nystagmus (lateral) is well marked.
Amblyopia is present.
The outline of the disc is irregular, but there is no neuritis.
No ptosis or ophthalmoplegia.

He complains of a dull headache, but does not localise it at all. Mental condition quite clear; he gives an excellent account of his symptoms. P. S. P.

A Case of Encysted Tuberculous Perimetritis.

ABSTRACT OF A
CLINICAL LECTURE BY MR. TARGETT.

THE clinical notes of the case are as follows:—

Jennie W., aged 21 years, single, was admitted for pain and swelling in the abdomen. She had not been well for nearly a year, and during the last six months she had suffered from pain and swelling in the right iliac region, with troublesome constipation. The pain was more or less continuous, with exacerbations of considerable severity, and it extended down the right thigh. For the last two months she had been obliged to give up her work, and was then under medical treatment. The case was regarded as either chronic appendicitis with inflammatory effusion, or possibly an inflamed ovarian cyst on the right side.

On admission (September 10th, 1907).—There was an obvious swelling in the hypogastric region, especially on the right of the median line. It felt cystic, and yielded a thrill, but its outline was very indefinite, and dulness was not complete over the front of the swelling. The uterus was displaced to the left of the pelvis, and there was some bulging on the right of the cervix uteri, though no distinct tumour could be felt there.

Menstruation began at seventeen years, and was regular every three weeks, lasting five days. There was usually severe pain for two days preceding the flow. Some leucorrhœa generally present. Micturition has been more frequent of late, but it is not painful. Constipation has been very troublesome for many months. No sickness. The girl was decidedly anæmic and had lost flesh, but pulse and temperature were normal.

Diagnosis.—The following conditions were discussed:—

a. Chronic appendicitis.—The attacks of pain in the right iliac fossa extending to the thigh, together with the chronic constipation, were in favour of this view. But the swelling was much larger than would be expected, there was a distinct thrill, and there were no symptoms of deep suppuration.

b. Ovarian cyst.—The chief points against this diagnosis were the indefinite outline of the swelling, and the subresonant note over it from adherent bowel. Moreover, the patient was anæmic and wasted.

c. Broad ligament cyst was suggested to meet the above objections to the common ovarian cyst. But such intraligamentous cysts extend downwards by the side of the cervix and vagina, and are therefore easily felt on vaginal examination.

d. Tuberculous effusion was most in accord with the patient's general condition of anæmia and wasting, and was compatible with the clinical history of attacks of severe abdominal pain and gradual swelling. An exploratory operation was advised.

September 16th. Abdominal section.—There was considerable difficulty in reaching the peritoneal cavity, because the intestines were extensively adherent to the abdominal wall below the umbilicus. The adhesions consisted of soft fibrous tissue, which had to be snipped through, as they would not break down under the pressure of the fingers. After separating several coils of bowel, a bluish cyst was exposed and tapped, and several ounces of serous fluid were evacuated. This bluish cyst was composed of two or three loculi formed between adhesions, and it was situated chiefly in the pelvic cavity, behind and on the right of the uterus, but not in the right ovary or tube. The left appendages were not seen, being matted to the left side of the pelvis. Old cretaceous tubercles were felt on the parietal peritoneum, and in the mesentery of the small intestine. Hence the lesion was of tuberculous origin, and may be termed an encysted tuberculous perimetritis.

The cavity was wiped out dry, and some of the membranous adhesions were removed. But in order to prevent bowel from getting into this adventitious cavity, the aperture was closed by drawing the edges together with one or two fine sutures. Although it seemed probable that the effusion was secondary to disease of the tubes, yet no hard masses could be felt such as would indicate caseous salpingitis.

The patient did well, and on leaving the hospital it was found that the body of the uterus was still drawn over to the left side. There was no thickening at the roots of the broad ligaments nor in Douglas's pouch.

During the next three months the patient improved much in health, and regained her colour. But early in the present year she began to notice a swelling of the abdomen, and a gradual failure of the general health. This condition has persisted until the present time, when it was found that the fluid had re-collected, forming a swelling which reached up to the umbilicus. The girl was again looking very anæmic, and had lost appetite and strength.

There was, however, little or no pyrexia, and she had no chest symptoms. On vaginal examination the uterus was found to be displaced to the left, as on the previous occasion. The right fornix was widened and somewhat distended. Through it a swelling could be felt bimanually, which was oval in shape and smooth on the surface. It was thought that it might be the dilated ampullary end of the right tube, and as it was quite clear that fluid had collected again in the lower part of the abdominal cavity, she was advised to have an exploratory incision made to remove the fluid and to discover the nature of the swelling felt through the right fornix. Before the operation the blood was tested, in view of the subsequent treatment with tuberculin.

May 14th, 1908. Second abdominal section. A small median incision was made through the scar of the previous operation. As the swelling was dull on percussion there was no anxiety as to adherent bowel. The peritoneum was easily opened, and about a pint of serous fluid was evacuated. Careful examination showed that this cavity was shut off from the general peritoneal cavity by adherent bowel. It was bounded in front by the abdominal wall, and above by the adherent bowel. Its inner or deep boundary was not at first clear, but subsequently the following condition was made out. The pouch of Douglas was closed in at the top by having the uterus and right broad ligament stretched back over it and adherent to the posterior wall of the pelvis. The limit of the right broad ligament could be detected by the right Fallopian tube, and the rest of the roof of the pelvic cavity was formed by a bluish membranous adhesion. This membranous adhesion was broken down with the finger, and another quantity of serous fluid was evacuated, some five-and-twenty ounces in amount. Thus the abdomino-pelvic swelling consisted of two loculi, viz., (1) a distended Douglas's pouch roofed in by the retroverted uterus, the widened right broad ligament, and adventitious adhesions; and (2) a cavity in front of the uterus and occupying the hypogastric region. On exploring the pelvic cavity a swelling was found, which proved to be the right ovary, cystic, and enlarged to the size of a goose egg. It had formed adhesions to the right wall of the pelvis, and the right tube was also adherent to it. The right appendages were now removed by tying the tube close to the uterus and ligaturing the broad ligament in segments, and finally detaching the ovary from its pelvic adhesions. The right tube was thickened, but there were no obvious signs of tubercle in it, and microscopical sections merely showed fibrosis of the wall and surrounding cellular tissues.

The left appendages were not seen, being still matted down by adhesions, as at the previous operation. The uterus was freed of adhesions, as far as possible, and the fluid in the cavities was wiped out dry. No irrigation used, and no drains left in. Abdominal incision closed in the usual manner with buried catgut sutures.

Since the operation the patient's general health has once more begun to improve. She is spending the whole day on the balcony, is taking food and cod-liver oil freely, and is regaining her colour. The tuberculin injections have been commenced. Though the microscopical examination of the Fallopian tube did not reveal the presence of tubercle, there can be no doubt that the case is an example of encysted tuberculous effusion. Inasmuch as the lesion is limited to the pelvic and hypogastric regions, and as there are no symptoms of any intestinal affection, I still think that the disease has probably originated from the tubes, though it may now be obsolescent in them. The prognosis would seem to be distinctly favourable, in spite of the rather rapid recurrence of the effusion after the first operation. Her speedy convalescence on both occasions points to the value of removing the effusion. At the same time, the general treatment of the case must be carried on thoroughly for many months.

The frequency of tuberculous salpingitis has been estimated at 10 per cent. of all cases of salpingitis. I have selected a series of specimens to show the morbid anatomy of tuberculosis of the female pelvic organs. But before dealing with them we must consider the various modes of infection.

I. *Infection through the blood-stream.*—In a certain proportion of cases the disease appears to be limited to the Fallopian tubes, and it is probable that in these cases the bacilli are introduced into the circulation through the medium of the lymphatic glands. The tubes must be regarded as "seats of election" for tubercle, especially the ampullary ends which are nearest to the blood-supply. The bacilli are then conveyed by the vessels to the mucosa of the tubes.

II. *Infection from the peritoneum.*—The serous covering of the tubes may be involved in a diffuse miliary tuberculosis of the peritoneum. But apart from this condition, which is of no special importance, it has been found that fluid in the peritoneum will convey organisms into the tubes through the patent abdominal ostia. This

method of infection would explain the fact that the ampullary segment of the tube is usually first involved. It has been shown experimentally that finely-powdered cinnabar can be introduced into the tubes by means of the currents of fluid in the abdominal cavity, and bacilli set free by tuberculous ulceration of the bowel might thus be conveyed to the Fallopian tubes.

III. *Infection by extension from other organs.*—This method is probably rare, but I have seen a right tuberculous salpingitis firmly adherent to the cæcum and appendix which were the seat of extensive chronic ulceration. The left uterine appendages were normal; hence the disease probably spread from the cæcum to the right tube. In another instance tuberculous ulceration of the ileum led to adhesion and secondary invasion of the uterus. Similarly, ulceration of the rectum or bladder may produce fistulous openings into the vagina.

IV. *Infection from external sources.*—That infection of the lower genital tract by the use of instruments, sexual intercourse, and contamination by discharges from the rectum is possible, cannot be denied; but I am disposed to think it is very infrequent. Primary tuberculosis of the cervix and vagina, vulva, etc., is very rare, and the same is true of the prepuce and glans penis of the adult male. Moreover, the cases of primary tuberculous ulceration of the cervix have shown no tendency to extend upwards to the body of the uterus. Hence, ascending infection of the Fallopian tubes is rendered improbable, though in numerous experiments upon rabbits a small percentage (12 to 14 per cent.) of success has been obtained.

I will now show some lantern slides on the screen, illustrating the three main types of tuberculous disease as it affects the Fallopian tubes and body of the uterus.

I. *Acute tuberculous salpingitis.*—Note that the tube is cylindrically enlarged to size of tip of finger, and its canal is entirely blocked with the swollen and infiltrated mucosa. The serous coat is healthy. This case simulated acute appendicitis: a girl, aged 22 years, was taken ill suddenly with severe abdominal pain, sickness, rigors, and pyrexia, and signs of acute peritonitis in right iliac region. On laparotomy: the appendix cæci was healthy, but the right tube was much swollen and acutely injected. The nature of the lesion was quite unsuspected. Case did well. (Other examples of this type were exhibited.)

II. *Caseous tuberculous salpingitis.*—In these specimens you will observe either a diffuse or a nodular thickening of the tubes. On section their lumina are filled with yellow caseous material in various stages of degeneration. The serous coat is usually infected with recent tubercle, and the amount of peritoneal adhesions will depend upon the associated inflammatory reaction. In some specimens this is very slight; in others, the caseous tubes are embedded in the densest adhesions, and plastered with tuberculous exudation to the pelvic wall, so that removal by operation is impossible. Note also that the uterine cavity is granular from tuberculous endometritis with ulceration, but the cervix is not affected.

III. *Tuberculous pyosalpinx.*—The third type of specimen is very remarkable, and its appearances are quite characteristic. Both tubes become distended into large banana-shaped cysts which arch round their corresponding ovaries. The abdominal ostia are closed, but their fimbriæ persist as prominent fringes at the outer poles of the cysts. The serous surface is almost free of adhesions, and exhibits no peritoneal infection with tubercle. The wall of such tubes is usually thin and ulcerated, and may show no evidence of tubercle on microscopical examination. But I have found that the thickened undilated uterine end of the tube shows the disease, and this part of the specimen should always be examined for the purpose. Such dilated tubes are often filled with a puriform, or honey-like material, which is devoid of pyogenic organisms, and frequently does not contain tubercle bacilli. Hence the importance of examining the uterine ends of the tubes in order to discover the nature of the case. The clinical symptoms of this affection are vague. Thus, in two or three instances, the patients came under observation for dysmenorrhœa and sterility. There was no vaginal discharge, no menorrhagia, and no family or personal history of tubercle. The swellings were removed by operation, but their nature was only cleared up by microscopical examination.

Though the body of the uterus is much less frequently affected than the tubes, yet, as might be expected, the disease in it assumes nearly the same forms as in tuberculous salpingitis. Thus we may have—

1. A diffuse tuberculous infiltration of the endometrium, corresponding with the miliary type of salpingitis already described. In the uterus now shown you will observe that the endometrium is much thickened and thrown into coarse rugæ, but there is no ulceration. The disease has invaded the whole length of the cervical canal. Clinically the case (aged

35 years) presented swelling and redness of the portio vaginalis, like a large "cervical erosion," and there was a persistent blood-stained discharge. Malignant disease was suspected and vaginal hysterectomy was performed. Death from suppurative peritonitis resulted, and the autopsy revealed adherent pericardium and caseous pelvic glands. The condition of the Fallopian tubes is not mentioned.

2. Caseous endometritis has already been seen in some of the specimens of caseous salpingitis. It takes the form of a finely granular membrane which has replaced the endometrium, and is associated with infiltration and ulceration of the muscular coat of the uterus.

3. A tuberculous pyometra may be produced and is comparable with the tuberculous pyosalpinx above described This specimen is a good illustration of it. The uterine cavity is much dilated and its wall thinned. The endometrium displays groups of punctate ulcers which tend to coalesce, forming larger ulcerations. Blockage of the internal os has led to dilatation of the cavity. A similar condition of punctate ulceration is met with in the earlier stages of tuberculous cystitis.

There is one other condition of pelvic tuberculosis which I am able to illustrate with specimens. It may be termed encysted caseous perimetritis. Douglas's pouch becomes distended with pus, or puriform fluid, and the uterus, with its adnexa, is pushed forwards, and firmly glued to the anterior pelvic wall, bladder, and abdominal wall by a thick jacket of tuberculous exudation, which covers the interior of the pelvic cavity in all directions. The upper and front boundaries are formed by adherent bowel. It is difficult to recognise the pelvic organs in such specimens without much dissection, though the fimbriated ends of the tubes may be quite distinct and patent. Probably the infection proceeds from the bowel, and it may be conveyed to the tubes subsequently through the patent ostia.

With regard to the diagnosis of tuberculous salpingitis, a few general points should be borne in mind.

a. The previous history of the patient is important, especially as to past tuberculous lesions of the glands, lungs, joints, etc.

b. The absence of the more usual causes of salpingitis, such as sepsis and gonorrhœa, is a valuable guide. A distended tube in a virgin is almost invariably tuberculous.

c. Menstruation may not be disturbed in tuberculous salpingitis, or it tends to be suppressed. But in other forms of salpingitis there is usually menorrhagia or irregular hæmorrhage.

d. Dysmenorrhœa and sterility have already been mentioned as commonly present.

e. Absence of pelvic pain has frequently been noted. This symptom seems to depend on the presence of adhesions of an inflammatory nature, and as long as the serous coat of the tube remains free from adhesions and tubercles, there is likely to be freedom from pelvic pain. In the cases of distended tubes there are no recurrent attacks of peritonitis, which are so characteristic of the common pyosalpinx.

f. Examinations of vaginal discharges for tubercle bacilli, and of the uterine curettings for tuberculosis have been regarded as important tests. But in my experience tubercle is very rarely found in uterine curettings, so that a negative result would be of no value in the diagnosis of tuberculous salpingitis.

Appointments.

Civil.

Glendining, B., M.B., B.S. Durh., has been appointed Clinical Assistant to the Chelsea Hospital for Women.

Leathes, J. B., M.B., B.Ch. Oxon., F.R.C.S. Eng., has been appointed a Public Examiner in Animal Physiology at the University of Oxford.

Naval and Military.

Surgeon G. Carlisle, R.N., has been appointed to the *Barfleur*, and Surgeon A. Wernet, R.N., to the *Majestic*.

Major S. E. Prall, I.M.S., to act as Port Surgeon, Aden, and in Medical Charge, European General Hospital, Aden.

Captain L. Hirsch, I.M.S., is appointed to act as Civil Surgeon, Cochin.

Captain H. Watts, I.M.S., is appointed District Plague Medical Officer, Ambala.

Pass List.

University of Cambridge, May, 1908.- Degree of M.D. conferred: Ronald Edgar French, M.A., M.B., B.C.

University of London, M.B., B.S., Examination, May, 1908.—Honours: Mr. A. N. Leeming (distinguished in Medicine). Pass: Messrs. G. N. Bartlett, E. L. Martyn Lobb, O. Marriott, H. Stott.

Royal College of Surgeons of England, May, 1908.—Final F.R.C.S.: R. Davies-Colley, S. W. Daw. Primary F.R.C.S.: B. Glendining, G. Maxted.

Medical Department, Royal Navy.—Examination for Surgeon: Arthur T. Rivers.

Notes of a Roving Guy's Man.*

IV.

Writing home while on his travels, the younger Moore complained that there was too much to see, and too little time for seeing it. That was three hundred years ago, and to-day the task of the student who wishes to be catholic is worse than Sisyphean; one cannot even make the stone mount to the top, for it is impossible to survey everything. And yet a strict attention to one branch only, whether in surgery or medicine, is probably not the best the student can do while visiting Continental hospitals and centres. A conception of the advance in German surgery is, for example, greatly helped by a knowledge of the modern development of German medicine, and *vice versâ*. The pity is that one cannot do justice to both branches of study. One can only turn to that subject which one feels attracted by, or in which one's own hospital has not given sufficient opportunities for study, throwing in, wherever possible, a visit to a clinic, or an attendance at a demonstration whereat other subjects are put more prominently into the foreground. At Berlin this impossibility of going everywhere is especially regrettable, because there are so many subjects ably treated by able men. In medicine, Excellence von Leyden, Professor Senator, and Professor His, claim consideration from any visitor, and in other subjects equally well-known men lecture or demonstrate. Yet it is manifestly impossible to visit their classes, and to make full use of the opportunities their teaching offers. A few medical clinics, however, I have been able to visit. Among those comes easily first the excellent clinical demonstrations of Dr. Oppenheim, which remind one of those instructive Out-patient afternoons at Queen's Square when Dr. Russell was "in the chair." The clinic is a private one, but is one of the most popular in Berlin, and is attended by many surgical men. For Dr. Oppenheim—and his is not an isolated case—has always worked hand in hand with his surgical colleagues, and, as in the case of Mikulicz and Naunyn, the combination has produced excellent results. The demonstrations are much more suited to the needs of qualified students than of those going in for examination; in fact, the teaching, if one can call it so, is by suggestion. To a Guy's man, who does not have much opportunity of studying nervous cases, Dr. Oppenheim's clinics are a really enjoyable function, and one comes away with a mass of notes on original points, any one of which would be sufficient for a theme for a thesis! At Professor Senator's it is slightly different: his methods are more for the unqualified student, and, as with von Leyden, one is struck with the great stress laid on essentials of observation. The use of the stethoscope, for example, is almost discouraged, at least in the case of junior men, but great attention is paid to inspection, palpation, and percussion. Correctness of observation seems to be the leading object of teaching, and one can only admire the way in which small details are constantly presented to the student. Thus, in a case of phthisis, half the time was spent in pointing out what one might call "the picture" of the case. The minute arborescent dilatations of the superficial veins over one apex (which somebody has described as a new sign, but which old Phillip Morton wrote of), the red line on the lower gums, the nails, the hand creases, the hair, the pigmentation round the umbilicus, the carriage of the body, the breathing in different postures, and all the hundred and one little points were gone over before the lungs were auscultated. Only in Italy have I seen a more full demonstration of a case, and certainly in other German towns the teaching in essentials is by no means so thorough.

Recognising the impossibility of being ideally catholic, I decided to devote most of my time to one subject, and as at Guy's there was but little chance of gaining a good practical acquaintance with orthopædics, the unexpected opportunity of working under Professor Klapp at the Royal Orthopædic Clinic was too good to be lost, especially as it gave one the chance of attending Professor Joachimsthal's Out-patients late in the afternoon. Attending and working here from early morning till two in the afternoon, every day of the week, one sees plenty of cases and has an opportunity of studying comparative methods. Chances for operative work, be it added, are not few and far between, although with so many assistants they are necessarily distributed in such a way that no one gets very many. Nevertheless, with several reductions of congenital hips, an osteotomy and a tendon transplantation in one week, one cannot reasonably complain.

One of the first points that struck me, working at this clinic, was the treatment of tubercular joints. The first patient I saw was a poor-class woman with tuberculosis of the ankle-joint. There was no doubt about the diagnosis—the patient was twenty-three years of age—and the condition of the foot was typical—a good deal of swelling, tenderness below the internal malleolus, and much limitation of movement. With us, such a case is treated on the usual lines—fixation and immobilisation in plaster—with, as I had experienced in two cases recently, by no means encouraging results. The poor things drag themselves to and from Outers on crutches; the foot is never properly at rest, and these working women cannot afford the time to "lie up." So bad is the result in general that one often wonders whether, in such patients, amputation is not, after all, the best treatment. I may have seen unusually bad cases, but hitherto my experience of tubercular ankles has been extremely discouraging. Here these patients are treated in a totally different manner. No attempt whatever is made to fix the joint or to render it secure from movement. All that is done is to put on a Lorenz splint attached to a plaster casing that reaches to the head of the fibula (therefore not above the knee joint, as with us). This plaster casing is split along the front, and is

*Series I., II. and III. of Notes appeared in GAZETTE of April 4th, May 2nd, and May 16th.

secured to the calf by a double strap, above and below. The splint is padded inside; the foot is not bandaged (except when there are sinuses, in which case a dressing of vioform gauze is applied), but swings free above the heel plate of the Lorenz splint, on which the patient walks, a compensatory heel being attached to the sole of the boot on the sound side. In this apparatus the patient walks about as easily and comfortably as one can under such conditions. She attends daily, when the splint is taken off, and (if there are no sinuses) an elastic bandage is applied round the thigh to render the lower leg hyperæmic. This bandage remains on from twenty minutes to an hour. The foot and lower leg swell, become bloated, blotched (not cyanosed) and warm: all pain vanishes under such hyperæmic treatment. Where sinuses exist, the hyperæmia is produced by suction cups applied directly over the sinus. The patients are not allowed to put on the bandage or cups themselves at home, but apply these at Out-patients. They all speak very highly of the way in which this hyperæmic treatment eases the pain and "makes the foot comfortable." I have not had time enough to judge my own cases. The one above mentioned, first seen six weeks ago, is, however, very much better. The ankle can be freely moved and is not tender, but there is still some swelling. The main point in the treatment is to prevent the part from bearing pressure on the affected joint. Anyone familiar with the changes in tuberculous bone (so well described by Mr. Barker in the old Holmes' System of Surgery) must appreciate the effects of weight and pressure in such a condition. Absolute physiological rest in a joint is very difficult to obtain—in out-patients, impossible. Nor, they say here, is it necessary to endeavour to get such rest. The joint is, therefore, left free. The patient is allowed to move it, and it is, indeed, passively moved by the physician every time the hyperæmic treatment is applied.

To me, and I daresay to many Guy's men, these principles come as absolutely novel. The direct declaration, made when the first case was treated, "in all cases of tuberculous joints you must attempt not only to secure the cure of the disease, but a moveable, useful joint as well," came as a revolutionary, almost as a heterodox statement. "Surely, herr professor, you do not obtain a moveable joint in a case of tubercular coxitis?" "Certainly, if the case is properly treated. You will see the results for yourself." I have seen the results, and without doubt they are far superior to anything we obtain by conservative methods. I have seen ankle and knee joints which, to judge from the written "condition when first seen," the X-ray photographs, and the patients' own statements, were, when treatment was begun, immobile, fixed, with sinuses and with a certain amount of destruction. Now they are flexible, allowing all movements, not, of course, to the full normal extent, but to an extent that makes them useful, stable joints. This result is especially striking in hip cases, and is due, to a large extent, to the early passive movement and the hyperæmic treatment. Whether these joints are "cured" is quite another matter, and one upon which I should not care to express an opinion. In ten years' time the statistics may be valuable. At present they are comparatively worthless, as the time is much too short.

As with general surgery, the work in orthopædic surgery is not superior to what one can see in England. Even those who have not journeyed to Westminster or Liverpool will have seen good orthopædic surgery and good demonstrations. To Guy's men who have had the pleasure of following Mr. Symonds round the wards when he was in a mood to talk about apparatus, a great deal of what is taught here will be old. For all that, the study of methods is, in this department as in that of intestinal work, of great value and interest. I have already alluded to the treatment of tubercular lesions. Tubercular spondylitis is treated by a slightly different method—more like our own. Plaster beds will not be new to Guy's men (though I doubt if any of our dressers have ever made one!), but the excellent results of their use I have never seen so well demonstrated as here. The manufacture is perfectly easy (I believe Cheyne and Burghard give an account of it), and it is well worn by the child. A few words on materials may, perhaps, be interesting here. At Joachimsthal's clinic (which is a private one) celluloid is largely used; at the Royal Clinic plaster bandages are used almost exclusively. Simple Hessing's apparatus, with leather cases and steel supports, are used in cases of flail joints, etc. The Lorenz splint already mentioned will be familiar to most. For purposes of comparison I have jotted down the prices (average). Plaster, with walking iron (as in tubercular ankle), 2s. 6d. to 4s. 6d.; plaster and iron for coxitis, 6s. 6d. to 7s. 6d.; plaster for club foot, 1s. 6d. to 2s.; Durana sole for flat foot, 6d. to 1s.; "Gyp's bed," 3s. 6d. to 6s.; "Gyp's corset," 3s. 6d. to 4s. 6d. In every case the patient is asked to contribute towards the cost; many pay for the whole. The leather splints, costing from 30s. upwards (they are made in the clinic by a special apparatus maker, and the Professor is keen that every worker should see them made and "be able, at least, to tell the maker where he has gone wrong,") are rarely used. Special plaster bandages are used with which it is really a pleasure to work, as they dry so smoothly and quickly. Starch is not used; one's hands are sprayed with Chiroseter before commencing work, and then simply washed in warm water.

In the case of a tubercular hip, the patient at first receives a complete splint that extends from above the iliac crest to the toes, and to which a walking iron is attached. This plaster splint immobilises the joint, but is not retained long. After six weeks it is replaced by a splint that only reaches as far as the lower end of the thigh. This is retained for a couple of months and then left off. Passive movement is begun early. Abscesses are aspirated and injected with iodoform emulsion. In coxitis and spondylitis it is difficult to see how the hyperæmic treatment can be carried out, and the principles laid down in the case of the ankle-joint are not fully carried out. Thus the joint is immobilised

so long as there is definite tenderness on pressure, and it is immobilised in a position of slight abduction and extension, in most cases an anæsthetic being given while the plaster is put on. In tubercle of the elbow and in cases of dactylitis tuberculosa no attempt at immobilisation is made. Tubercular coxitis is relatively common here—certainly not below tubercle of the knee, as Mr. Watson Cheyne's combined statistics tend to prove. Syphilitic coxitis—or what was supposed to be so (the case reminded me very much of a little boy under Mr. Dunn's care who was shown at a meeting of the Physical Society last session)—I saw one case of. This form of hip-joint trouble is stated to be excessively painful, and the boy was, I must admit, very irritable and whiny. I am told that adult patients usually cry out with the pain, especially at night, although there is no great tenderness of the joint. In this condition, and more especially in the tubercular cases, inunctions with Sapo Kalinus (Duvernay's soap) are said to be very useful, and are very much used. The gonorrhœal form I have not yet seen here. One, in the hospital at Bremen, was treated by injections of 10 per cent. solutions of protargol, which is said to be very effective. The whole subject of tubercular coxitis is, as Mr. Mantalini would have phrased it, "demnibly interesting," and the current views on it here are, perhaps, as open to argument as those that prevail with us. The pathology is very well recognised: I found that the students, for instance, "had heard" of the diminution of the calibre of the femoral vein and artery which Lannelongue described, and of the alterations in the lymphatics of the hip-joint. Much stress is laid (at least at the Royal Clinic) on the early diagnosis, and "early tension or rigidity of the adductors of the thigh" is taken as presumptive evidence of a tubercular hip. The positions in the first and second stages are declared to be due to physiological causes, and the loss of the gluteal fold is rightly stated to be due to flexion, and not, as some of our text-books still maintain, to wasting of the buttock muscles. The treatment is especially to be appreciated by those who have attempted to reconcile Mr. Marsh and Mr. Wright's views; it is here summed up in one sentence, "Don't think of the scalpel." Conservative treatment is tried in every case; it is given a long and very patient trial, and only in exceptional cases (as, for instance, when Nature has already done the operation and the head lies free in a pool of pus) is resection advocated. The results are, on the whole, very good, but to take the whole of Germany, the latest statistics (those of von Brun's and Wagner for the Tubingen clinic especially) the percentage of "cures" (55 per cent.) is not much higher than with us.

While on the subject of the hip-joint one may be allowed to say a few words about those interesting conditions, *coxa vara* and *coxa valga*, both rare in England. Here they seem to be rather more frequent, the infantile form (the so-called *coxa vara congenita*, although it is really a static deformity and should properly be called rhachitica) being especially frequent. At Professor Joachimsthal's clinic I saw a case in which it was combined with slight congenital luxation, the right femoral head resting on the outer brim of a flattened acetabulum—the professor gave a bad prognosis, stating that such cases, although they looked easier, were really much more difficult to treat than more pronounced ones. The adolescent form of coxa vara (which Hoffa very aptly likened to "inflammatory flat-foot") is a much more interesting condition. The deviation in this form is almost always downwards and backwards, and it comes on fairly suddenly. The many theories on its causation have only, at present at least, an academic interest, and the treatment usually carried out here is oblique osteotomy. The valgus form is not so rare as is usually stated, although it is relatively less frequently brought to the clinic, because it gives rise to less subjective symptoms. Both varieties are said to be rarer in Berlin than in Bavaria. Equally interesting is congenital luxation of the hip—a condition which is astonishingly frequent here. I do not remember to have seen more than five cases in England, three of which I saw at Out-patients at Guy's: here I have seen as many in one week at one clinic alone. Into the details of the condition I need not go, but men who are familiar with the short and concise account in Rose and Carless may be interested to hear that there are at present no less than twelve different theories of its causation, and, as German examiners are very fond of all, the student is expected to give details of each! The most attractive one is the subtle "defects in the ovum" view, which is now hauled in to explain most things which the pathologists cannot fathom—from wry-neck to varicose veins. The diagnosis is usually quite simple—here it is made by the walk, which is characteristic, or by Trendelenburg's sign. Among the conditions which may be confounded with it are rickets, coxa vara and valga, paralytic luxations, pathological luxations, spontaneous separation of epiphysis, and the various varieties of coxitis. The treatment is the most interesting, and here again one is interested to find that, in theory, there are no less than fifteen different methods of treatment. These range from the girdle, corset, and bed treatment to the open operations of Mikulicz and Hoffa. The open methods are now given up here, and everyone practically agrees with Mr. Jackson Clarke, who considered that the open operation was not justifiable. It produces an ankylosed joint, and its dangers are by no means theoretical. Hoffa, however, still held to the method up to his death, though Mikulicz abandoned it soon after trying it. The favourite method here is the so-called "bloodless reposition"—a bad name, for the operation is probably by no means bloodless! Of this there are four variants, Paci's method, Schede's (in which an osteotomy is done to correct the femoral torsion), Mikulicz's (in which the reposition is gradual and by means of special apparatus), and Lorenz's. The last-mentioned is practically the only one used, and gives most excellent results. The child is anæsthetised, and laid on its back with its pelvis projecting over the table (usually the Schede's pelvic rest is employed). One assistant grasps the pelvis firmly, without undue pressure; a second pushes the trunk downwards, grasping the child round the chest, high up. The operator takes the thigh

and gets a firm hold on the femur, and then does four movements, which may be made quickly or as slowly and deliberately as desired. These are extension, flexion by levering it upwards towards the abdomen, inward rotation and slight abduction. The head can easily be felt slipping into the acetabulum, not only by the operator, but by the assistants as well. Such reposition is quite easy as a rule; when the muscles are very rigid, steady pulling on the leg usually suffices to overcome the resistance. Adductor tenotomy is very rarely done. But once the head is replaced the operation is by no means over; it has to be made to stay there. The operator works the head backwards and inwards, steadily and patiently, and employing a certain amount of force, until the limb can be adducted, abducted, flexed or extended to a certain extent without the head slipping out again. These "rotatory movements" are very important, and they are very efficient. They are supposed to deepen the acetabulum by working out the comparatively soft tissue that fills it, but probably their efficiency depends as much on the fact that they tire out groups of muscles. One has to go on for quite a long time with these movements, trying their success every few minutes. When on flexion the head slips out, the back wall of the acetabulum is chiefly attended to; when during extension the front, and when during adduction the outer wall, and so on. Usually after a quarter of an hour's fairly hard work, one has the delightful contemplation of a hip-joint that can be bullied about without getting dislocated! Then a plaster bandage is applied, a hole being left over the head of the femur to allow of a control X-ray picture to be taken afterwards. The more carefully and thoroughly the rotatory movements have been done the less abduction is needed, and I have put up a case with very little abduction indeed, so that instead of the thigh being at right angles to the trunk, it is slightly flexed and makes a very obtuse angle with the side line of the body. The plaster is carried up to the thorax, but is afterwards cut down. While it is being put on, the upper assistant has to push down the trunk as much as possible. The patient is X-rayed to see if the acetabulum really holds the head—if not, everything has to be done over again—and goes home, being able to walk about quite well with the help of a "walking chair." Double luxations are treated simultaneously. In very bad cases, where it is impossible to obtain reposition, resection is advised. As carried out here, the treatment is extraordinarily simple, and anyone can obtain very good results as long as the essentials are carefully observed, and the rotatory movements are kept up till the head is so well fixed that various movements can be executed without its leaving the socket. It is really wonderful how the children walk and enjoy themselves while in the big plaster splint. The nastiness of the method, from the assistants' point of view, comes after the splint has been put on, when the holes have to be cut and the ends rounded off. This is done while the plaster is still wet, and great care is taken to "mould" the splint very accurately to fit the pelvic crests. With careful padding there is no risk of over-pressure. Two years' treatment usually effects a cure. In passing, I may mention the fine results obtained in the X-ray room at the clinic. The photographs, even of deep parts, are obtained by instantaneous exposures—you press a button, there is a flash, and—the lady who develops things does the rest. With this, too, the Professor urges his assistants to be familiar; but I am afraid the principles are too technical for my poor comprehension to follow. I can admire, but that is about all. The marvellous quickness depends, I believe, on the use of a special piece of appparatus, the griosonator, and of specially constructed thin glass Bauer's tubes. The photographs obtained are wonderfully clear and distinct. In some cases joints are distended with oxygen before being skiagraphed. The resulting photographs show the outlines very clearly. Even more striking are the so-called "Relief X-ray photographs," which are really negatives from a positive. Both methods are, I believe, used by Mr. Jones at the Liverpool Hospital with very great success.

Another very interesting method at the Clinic is the treatment of scoliosis. Rachitis, the *Englishe Kraukhert*,* as it is called here, seems to account for but few of the cases that come to the Clinic, and these are, for the most part, the more severe ones. To begin with, there is no such distinction in terms as with us. At Guy's the teaching is that scoliosis is lateral curvature plus rotation, and that there is a normal or physiological lateral curvature. Thus Mr. Dunn at Out-patients used to spring a mine under his attendant dresser by asking whether "the poor thing" standing with his back towards the consulting table was right or left-handed. Here, however, such physiological curvature is absolutely denied. There are only two physiological spinal curves, the upper dorsal kyphosis and the lower dorso-lumbar lordosis—all other curves are pathological deviations from the normal. This agrees very closely with the American teaching, as can be seen from the new edition of Lovett's well-known little monograph on spinal curvature, but it is not quite the teaching in London, where physiological lateral curvature is still spoken of. Being much interested in

* So called, not because rickets is more frequent in England than here, but in honour of Glisson, who is supposed to have first described the disease. This, as so many suppositions where historical facts are concerned, is entirely unwarranted, as Bootius, twenty-two years before Glisson, wrote an account of the condition. His words are very clear, "Infantibus caput grandescit; reliquum corpus contabescit; ossa in articulis tament; dextrum hypochondrium tumore æquali prominet. Hoc malum multis millibus infantum molestum est," etc. Virchow, who ought to have known better, thought that rachitis was a "coinage" of Glisson's to give a Greek similitude to the English word rickets. As a matter of fact (I give the statement on the authority of a Professor of Philology), rhachitis (and not rachitis as it is usually spelt) is a good Greek native, just as rickets was a well-known Greek disease referred to by Hippocrates and Suetonius. A somewhat similar error is made by those who still heatedly discuss the priority of Basedon, Graves, or Parry, in the description of exophthalmic goitre. Here the honour is given to Basedon; with us to Graves; in America, I hear, it has lately become fashionable to speak of Parry's disease. In Italy they go "right away back to bed-rock," and give it the name of the man who really first described it. There they call it "Flagani's disease," for Martin Flaianus wrote, very many years before Parry, an excellent account of the disease in which he even described the pigmentation. This, like so much good work that is done in Italy, remained unknown, just as the bandage which the Italian surgeon Sylvestri discovered, and which the late Professor Esmarch is usually credited with!

the question, I took every opportunity of verifying statements as far as possible. To start with, there is no sign of a physiological lateral curvature in antique statues or pictures of the nude, although such a curvature is usually present in pictures of old or debilitated persons. The two Cranachs in the Friedrichs Museum here are interesting examples of this, especially the "Hell Picture"—an unholy little horror that is fascinating by its grotesqueness and minute accuracy of detail, and ever so much more impressive than Dante's razor-edged topsy-turvy conception! Nor, taking a large number of normal individuals—as I had occasion to observe at a medical inspection of a batch of recruits—is such curvature present; it is, in fact, regarded as a sufficiently good cause for rejection for military service, just as varicocele is with us. But much more convincing are, I think, the anatomical changes in these cases of "physiological scoliosis." One finds, as the specimens here show very clearly, marked changes in the vertebræ, a slight rarifaction of the part lying towards the concavity—thus of the part bearing pressure a sufficient reason for refusing to accept the theory that such scoliosis depends on weight pressure—an atrophy of the pulpy disc, and a marked thickening of the laminæ. In every case there is a degree of axial rotation, sometimes, of course, very slight. These findings cannot be normal or physiological, although they are met with in a very large number of people, yet I am still inclined to believe that a physiological lateral curvature may be present in some few cases. Garston proved that 90 per cent. of normal persons have asymetrical femora, and that exact levelling of the iliac crests is only present in 12 per cent.—facts which must be very comforting to all of us who have to treat thigh fractures. If that is the case, much of this pathological scoliosis may be due to unequal length of the lower limbs. Here three grades of scoliosis are described, as by Lovett. The first is "habitual," and agrees with our physiological and with Lovett's "habit curvature," except in so far that here it is stated that such curvature may be double, say left-sided dorso-convex and lumbo-concave, which is not admitted by Lovett. The second degree is where the rotation is marked; the third is the extreme form with enormous obliteration of the "side angle" on the side of the concavity. The objective signs are always very well demonstrated even in the slightest cases. They are five in number—the "shoulder sign," the "pelvic sign," the "foot sign," the "side angle sign," and the "dorsal boss." In most cases there is slight eversion or even flattening of one foot, the pelvis thus being tilted. The dorsal boss, which is due to the prominence of the head of the ribs, is found on the side of the concavity, the tilting of the shoulder on the convex side, the obliteration of the side angle on the concave side. Errors of refraction, constipation, and constitutional disturbances are attended to before treatment is begun. This treatment is largely gymnastic, and varies with the theories of the various professors. At Professor Joachimsthal's there is a large ante-room with swings, parallel bars, "rocking bars" and stirrups, in which the youngsters mess about to their heart's content, retiring when they have had their hour's "turnen" to a side room, where they are massaged. In a few very bad cases of the third degree plaster beds are worn, but apparatus is not favoured. At Professor Klapp's clinic the "crawl method" is in vogue, and really it is a sight to see two score or more youngsters, whose backs show all degrees and variations of curvature, from that of the Devil in Le Sage's exhilarating romance, to our "physiological curve," progressing round the gymnasium on all fours, and attempting to swim on the floor! They patrol round in triple file, keeping up an animated conversation all the time and criticising the efforts of new comers in the batch. Various batches—girls and boys—are given half an hour, and usually the room is occupied from two o'clock in the afternoon till six, the batches being in charge of specially-trained nurses. After the crawl, the kids (who in some cases are adults) lie on their stomachs and kick their heels in the air. Then they carry in forms and tie themselves to these by straps, first round the thighs to exercise the dorso-cervical muscles, and then round the chest to strengthen the dorso-lumbar groups. It is great fun watching these batches. The youngsters take a keen interest in the work, and are quite ready to show their paces. A new-comer with third degree curvature is a source of much interest and has to undergo a rigorous cross-examination by his batch mates. The exercises are complicated and difficult to explain, but Professor Klapp has been good enough to allow me to take photographs of the various positions and of the batches, some of which I hope to forward the GAZETTE later. The result of the treatment is very good indeed. The girls all become lordotic, the boys somewhat less so, and the lateral curvature entirely disappears. The glutei and trunk muscles get well developed, and so do the triceps and shoulder muscles, while the head movements seem to affect the sterno mastoid and the trapezii which stand out very prominently even in young members of the crawl batches. In weak patients systematic massage is employed. The children are excused from school attendance while being treated, and their eyes are always carefully attended to, any errors of refraction being corrected by suitable glasses.

Turning over my notes, I find several other interesting points, interesting to me at least, and perhaps not without interest to others as well. One of these is the treatment of some cases of sciatica. Everyone who has had a case of this condition to treat knows how extremely difficult it is to effect a cure in many cases. Ordinary obstinate sciatica is here treated by "bloodless stretching," or by Hölscher's or Lange's method. Hölscher exposes the nerve and puts on it a small compress soaked in 5 per cent. carbolic acid lotion. Lange injects as much as 100 c.c. of β eucaine (1 in 8 normal saline) solution directly into the nerve. A large, thin needled Roux syringe is used, and the patient yells when the nerve is touched; otherwise the operation is painless. Once you hear the patient yell, go ahead, you're

right in it! But a much more important treatment (apart from attending to the constipation from which sciatica patients nearly always suffer, and which is treated by massage, cold water enemata night and morning, and suitable diet) is to recognise a form of sciatica which is easily cured by means of a splint or plaster bandage. Goldschmidt, of Boston, drew attention to this form some years ago. In many patients, especially those who do much manual labour, or are weak, the sciatica depends on a weakening of the sacro-iliac ligaments and a partial subluxation of the sacro-iliac synchondrosis that results. The diagnosis of these cases is sometimes difficult, and ought not to be made until all other causative factors have been eliminated. A sign on which stress is laid in the differential diagnosis is the "stretch pain sign." When the sciatic nerve is stretched by flexing the thigh against the abdomen, the patient, in a case of ordinary sciatica, feels pain along the nerve, and such pain is very much increased when the tension produced by the stretching is doubled by extending the knee. In the case of a "sacro-iliac sciatica," such stretching gives little pain and is never made more painful by extending the knee. Measurements and X-rays are useful in diagnosing such cases. The treatment consists in applying a well-fitting plaster spica or thigh and pelvis splint which the patients wear for quite a long time. This apparatus relieves them of all pain and discomfort, but a relapse is unfortunately common when the splint is discarded, even after a comparatively long time.

Equally unsatisfactory is the treatment of congenital club foot. Here, to judge by results, the success obtained is much greater than with us, and is due to the great care with which every individual case is treated. At the Royal Clinic, conservative methods are in vogue; a tenotomy, osteotomy, or cutting operation is done only as a last resort. The club foot baby is handed over to the assistant, who, by passive movements, which are continued for hours perhaps, has to bring the foot into a normal or over-corrected position. It is really astonishing to see what mere hand work, carefully and perseveringly done, can accomplish in these cases. In one of my cases both feet were turned so that the dorsum had become the sole and the ball of the big toe pointed outwards; practically no reduction was possible, and I certainly thought a wrench would be necessary. But long-continued passive movements, not very forcible, but made methodically, brought about an entire change of position, and the feet could be put up in an over-corrected position in a plaster bandage. Usually a durana metal sole is incorporated with the foot bandage. In adult cases the manipulation is much more forcible, done under an anæsthetic, and usually with a wrench. Passive movement is continued whenever the splints are taken off, and the musculature is systematically massaged. The operative methods are not new, but they presented some features which I had not seen elsewhere. Thus, Lange's artificial tendons are used to a large extent, and appear to give good results, and the lengthening of tendons is done in the American fashion, by "nicking and pressure," a very neat and pretty way. Tendon transplanting is rightly condemned in young individuals, and in no case is ever done on an infant. What I have seen of the results of the operation here and elsewhere is not very encouraging. Primary results are usually good, but patients soon lose what they have gained, and in very few cases are the good results permanent. This is particularly well seen in cases of paralytic pes calcaneus, in which astragalectomy and a side splint seem to be much more effective.

Work at the clinic is interesting enough and by no means monotonous, although there is a constant recurrence of similar cases, and one gets somewhat tired of knock knees and flat feet. Out-patients start coming in at half-past seven in the morning, but the regular attendance hour is nine o'clock, although in the Orthopædic Department there is nothing to do before ten o'clock. So one has plenty of time to come quietly, and the excellent tramway system makes it easy to reach the clinic from any part of the city or its suburbs. The tramways are indeed praiseworthy; they run in all directions, and for a penny fare one can ride for more than an hour from one end of Berlin to the other, or, if one has the desire so to waste one's time, one can circle round the city also for a penny! Equally cheap—and a deal quicker—are the 'buses, mostly motor. The clinic is located in the large Royal Surgical Clinic Block, which is by no means up to date. The wards are small, cramped and badly ventilated. The Out-patient rooms are a little better. The Orthopædic rooms are very similar to the Front Surgery at Guy's, except that the dressing-rooms are larger. Before any orthopædic patients arrive one is at liberty to stroll about and pick up any bits of knowledge that may be drifting about. Sometimes one lights on specimens of quite unexpected interest. One morning, when Outers was very full, I helped to dress a row of old patients, one of whom was a boy whose hand had been amputated. Entering into conversation with him, I learned that he had fallen on his hand, more than three months back, and broken his radius. A splint was applied at a first-aid station, but it was so tightly put on that gangrene of the fingers and hand resulted, necessitating amputation. This is the first example of this often-described complication of fractures I have seen! Curiously, I saw a case of Volkmann's contracture the same week. The new theory of the causation of this latter lesion is interesting. According to Professor Hildebrand, it depends not on a primary sclerosing myositis, nor on interference with the blood supply, but simply on degeneration of the main nerves. Hildebrand describes the nerves as being constricted at one point and showing, just beyond the constriction, a bulbar enlargement. By resecting this enlargement and the segment of constricted nerve, and suturing the ends carefully, he has had good success in several cases. I saw Dr. Böhm operate at his private clinic on a case of extensive cicatricial contraction of the forearm, and looked out for these conditions

described by Hildebrand. In this case, however, none of the forearm nerves showed these characteristic features. A Tagliani was done, and the limb put up in a plaster bandage.

It is, of course, interesting to compare methods of teaching and theories here with those that obtain with us. At the orthopœdic clinic there is a batch of students, somewhat similar to our dressers, although their duties are much lighter and far less responsible, the "assistants," who are qualified, doing most of the work, and among them are several very energetic and enthusiastic Russian lady students. "Shop" is as common during the leisure moments as with us, and the argumentative style is largely cultivated, although when speaking to a qualified "herr collega" very great deference is paid to his opinions, even if they are considered heterodox. I have found myself involved in physiological discussions which reminded me of the afternoons spent at the Physiological Society—only that one got no tea—and I have been surprised to find how much weight is attached to purely theoretical physiology. I have been under the impression that blood platelets were artifacts (although my knowledge of Dr. Buckmaster's work is very slight), and, therefore, found myself "up a tree" when asked to explain "the *rôle* of the blood platelets in restoring the intima of a ligatured artery." Can any Guy's man do so? When I mentioned artifacts, the lady students exclaimed, "Is it possible!" in a tone of voice similar to that which Henry VIII. might have used had they told him that Queen Anne Boleyn was going to sue for a divorce! Of the discussions on the function of the basal ganglia, the types of alcoholic degeneration, and the even more mysterious subject of the complementary reactions in syphilitic patients, I have really not had the courage to take notes, as the amount of pathological knowledge demanded for their understanding is greater than the amount of patience required for learning Russian! Work is usually over by two o'clock, and one hurries to the nearest Bierquelle (the Berlin Lyons) for lunch, although lunch can be obtained at the clinic, if one chooses to eat it in the scullery. Many of the workers bring their sandwich, which they munch on the steps during a lull in the plastering operations. There is no stiffness or formality—all that is reserved for the Geheimrat when he comes round—and the time spent at the clinic is really enjoyed. In the evenings there is quite enough in the way of attractions—Destinn and Kunpfer at the opera, a bridge party, or a round of the cafés. Medical students, it may be stated, are admitted to the theatres at reduced prices, and—a privilege which our medical papers may well grant—can subscribe to the medical journals at a quarter of the ordinary subscription. There is, in addition, far less evidence of "sets," which are so irritating a feature in University life at the smaller centres, such as Gottingen and Griefswald. The professor or the chief assistant is always ready to give explanations and to enter into a discussion if time allows, and they know their work and literature very well. There are drawbacks, of course, but for the student who attends hospitals on the Continent, Ruskin's remark in the preface to the paraphrase of the Psalms may serve as a guiding motto, "To find out in what we agree, not in what we differ." Probably the first point that strikes the newcomer is the extraordinary deference paid to the chiefs of the klinic, and the overbearing, bullying tone adopted towards inferiors by the chiefs. This is not worse here than anywhere else, but it is striking enough, just as striking, in fact, as the regulations that forbid men like Oppenheim or Israels, who have a world-wide reputation in their specialties, from occupying a University chair. It is indeed a ludicrous anomaly that a civilisation which is agitating for the repeal of Clause 175 of the Penal Code, and which makes much of the Sultan, permits the existence of restrictions which debar the Hebrew from becoming a full professor or an officer in the Army. The loss, of course, is the University's, for so egregious an intolerance does not prevent Israels from attracting crowds to the Judische Krankenhaus to see him operate, or Dr. Oppenheim from similarly winning popularity as a teacher which is unrivalled by any full Professor!

Berlin, May, 1908. C. L. L.

Reviews, etc.

The price of books submitted for review should in every case be stated.

The Romance of Medicine. By Ronald Campbell Macfie, M.A. Aberd., M.B., C.M. (Messrs. Cassell & Co., Ltd.) 6s.

A most readable book! Dr. Macfie has given us an historical outline of Medicine from the very beginnings—the medical papyrus unearthed by Dr. Flinders Petrie near El Lahun, dated about 1600 B.C. to the modern development of bacteriology.

Of Hippocrates the author has much to say, of Aristotle little that is good. After the two Alexandrians, Erasistratus and Herophilus, who put medicine on a firmer basis by their exploits on the dissecting table, comes that Roman genius Galen, a Greek by birth and Alexandrian by education, a Roman by adoption. His great work in the cause of medicine cannot be overrated. Then the period of theological controversies, and an end to progress, until Mohammed appeared in Arabia, and following his demise came a remarkable epoch in the History of Medicine, an advance hindered by the Mussulman's inability—the Koran forbade it—to touch a corpse. Harvey and his discovery are dealt with at length, then a quaint chapter, "Man a Menagerie," tracing the understanding gained by the introduction of the microscope, and even dealing with Dr. Beard's Trypin Treatment in Cancer, and Metchnikoff's Lactic Acid Treatment of Old Age.

The section devoted to bacteria is the best in the book, but we think the author has hardly given Sir Patrick Manson his due, when speaking of malaria. In his chapters on anæsthetics, Dr. Macfie might have included

spinal analgesia, seeing how up to date the book is in some respects.

The book is written for the general public as well as the profession, so that, as one would expect, it is not unduly technical in expression. The style is good, in parts rather too racy perhaps, scientific facts being intermingled with topical allusions. Yet the book is of great interest and well worthy of reading. It is an admirable book to prescribe for your patient who asks, "Where can I read something interesting about medicine, doctor?"

Home Nursing and Hygiene. By Florence Hufton-Windust. (Adam & Charles Black.) 1s. net.

In every way an excellent book. It is written for that section of the public—and its name is legion—whose knowledge of the elements of nursing is nil. It is surprising really how limited is the average laywoman's knowledge of the A B C of the care of the sick. The author has set out to enlighten this public, and well has she done her task. The arrangement is admirable, the subject-matter beyond criticism, the language simple, too technical expression being avoided.

The poignant feature of the book is its excellently-expressed practical aspect. Choice of a sick-room, lighting, bedding, packs, baths, bedsores, all receive studiously detailed attention. The chapter on the administration of medicines and enemata, and that on external applications, is a masterpiece of practical facts. Children's disorders receive the same attention, and in discussing minor disorders of the body the author does not transgress the sphere of the physician, merely dealing with those maladies to which household remedies are applicable.

Many of the more serious ailments are outlined in such a way as to be useful in giving the amateur nurse such knowledge as will render the physician's instructions more easily understood. We cannot speak too highly of this little volume, and it should find its way into every household.

A Memoir of the Eminent Physician, Dr. Edmund Symes-Thompson, has been prepared by his wife, and will be issued immediately by Mr. Elliot Stock. Lord Balfour of Burleigh is a contributor to the volume, which also contains a portrait of Dr. Symes-Thompson, and other illustrations.

Mr. Elliot Stock also announces for immediate publication a Volume of *Original Poems*, by C. E. Stanley Thomas; also a new work entitled *What is Truth?* by the Author of "The Mission of the Cross."

Journals received.—Union Magazine; Medic. Temp. Review; The Hospital; The Clinical Journal; S. A. Medical Record; Middlesex Hospital Journal; Polyclinic; St. Bartholomew's Journal; Durham College of Medicine Gazette; London Hospital Gazette; St. George's Hospital Gazette; New York State Journal of Medicine; Calcutta Medical Journal; St. Thomas's Hospital Gazette; Manchester Medical Students' Gazette; The Prescriber; St. Mary's Hospital Gazette; The Practitioner; Le Mois Medico-Chirurgical; Journal of Balneology and Climatology.

Sport.

The Athletic Sports.

The Annual Sports took place on Wednesday, June 10th, at Honor Oak Park, in a blaze of sunshine. Thanks to the energy of Mr. Harris, the ground was in excellent condition, though, perhaps, rather too hard for comfortable running. There was a good attendance, and we were pleased to see so many ladies present. The standard of running was good. R. M. King ran well in the one mile and three miles. H. F. Renton in the hurdles had an easy victory and won in excellent style. H. N. Eccles must be congratulated on the fine half-mile he ran, and we hope he will be successful on Wednesday week. A. B. Danby showed good form and should make a very useful runner. Throwing the hammer was quite above the average, G. Tucker reaching the 100ft. mark, and R. Rankine doing 99ft. 0½in., the best performance on the ground for some years. Tucker was unfortunate in having to give such heavy handicaps. We were pleased to see H. Medlock win the 220 yds., and have to congratulate the new men for the keenness and good training they showed. The Lucas Challenge Cup was won by S. H. Browning. The judges and starters must be congratulated on the excellent manner in which they carried through a rather difficult programme, and special thanks are due to Mr. Fowler-Dixon for so kindly coming down to act as timekeeper. Much regret was expressed that the man with the donkeys had not put in an appearance, and the Honor Oak Scurry Stakes was perforce postponed. The details are as follows:—

100 Yards Handicap.—Heat 1: H. F. Renton, scratch, 1; G. D. Eccles, 5 yards start, 2. Time, 10⅘ secs. Heat 2: S. H. Browning, 3 yards start, 1; C. H. Medlock, 4, 2. Time, 10⅗ secs. Heat 3: H. Mather, 4 yards start, 1; H. N. Eccles, 3, 2. Time, 10⅗ secs. Heat 4: A. B. Danby, 5 yards start, 1; W. Cook, 3, 2. Time, 11 secs. Final Heat: Danby, 1; Mather, 2; Browning, 3. Won by six inches; good third. Time, 10⅗ secs.

Putting the Shot.—S. H. Browning, receives 4ft., 33ft. 3in. (actual put, 29ft. 3in.), 1; R. G. Oram, receives 4ft., 32ft. 5½in., 2; R. Rankine, scratch, 31ft. 3½in., 3.

Throwing the Hammer.—S. H. Browning, receives 25ft., 106ft. 5in. (actual throw, 81ft. 5in.), 1; R. Rankine, receives 5ft., 104ft. 0½in., 2; R. G. Oram, receives 25ft., 102ft. 4in., 3. Rankine threw 99ft. 0½in. and Oram 77ft. 4in.

Long Jump Handicap.—S. H. Browning, receives 2ft., 21ft. (actual jump, 19ft.), 1; R. G. Oram, receives 1ft. 9in., 19ft. 9in., 2; F. D. Berry, receives 2ft. 3in., 19ft. 7½in., 3.

High Jump Handicap.—S. H. Browning, scratch, 5ft. 3½in., 1: R. G. Oram, receives 2in., 5ft. 2in., 2; C. H. Medlock, receives 2in., 5ft. 0½in., 3. Oram and Medlock at first tied for second place, but Oram won on the jump off.

440 YARDS HANDICAP.—H. Mather, scratch, 1; G. D. Eccles, 10 yards start, 2; G. C. Covell, 5, 3. Won by five yards; a yard divided second and third. Time, 54⅘ secs.

HALF-MILE HANDICAP.—H. N. Eccles, scratch, 1; G. D. Eccles, 15 yards start, 2; G. Covell, 10, 3. H. N. Eccles made his way to the front forty yards from the tape, but "G. D." gave him a fine race and was only beaten a yard: three yards divided second and third. Time, 2 min. 6 secs.

ONE MILE RACE.—R. M. King, 20 yards start, 1; J. L. Johnson, 35, 2; G. D. Eccles, 40, 3. Also ran: N. E. Farr, scratch, and A. P. L. Johnson, 30. J. L. Johnson was prominent for three laps, but at the bell King shot in front, and staying very well won by twenty yards; forty between second and third. Time, 4min. 54⅘sec.

120 YARDS HURDLES HANDICAP.—Heat 1: H. F. Renton, owed 15 yards, 1; A. Moberley, owed 8, 2. Won easily. Time, 20⅗sec. Heat 2: S. H. Browning, owed 10 yards, 1; C. H. Gool, owed 8, 2. Won by inches. Time, 20⅗sec. Final heat: Renton, 1; Browning, 2; Moberley, 3. Won by a long yard: good third. Time, 19sec.

220 YARDS HANDICAP.—C. H. Medlock, 5 yards start, 1; H. N. Eccles, 3, 2; A. B. Danby, 5, 3. A capital race. Won by six inches; a foot divided second and third. Time, 23⅘sec.

THREE-MILE HANDICAP.—R. M. King, 15sec. start, 1; F. S. Adams, 50sec., 2; W. Levinson, 35sec., 3. Also ran: N. E. Farr, scratch, and A. P. L. Johnson, 30sec. King outdistanced all other competitors, winning with a deal of ease. He won in 16min. 22⅘sec., which, added to his handicap, gave his real time as 16min. 38⅘sec.

220 YARDS HANDICAP FOR EMPLOYEES.—Harris, 20 yards start, 1; W. Gray, 2.

Mrs. F. J. Steward presented the prizes to the successful competitors, and Dr. Fawcett, in a pretty speech, thanked her, and said how pleased all were to see the late president, Mr. Lucas, present. Mr. Lucas suitably responded.

Cricket.

GUY'S v. R.A.M.C.

Played at Honor Oak Park on Wednesday, May 27th, and ended in a win for the Hospital by 202 runs. Scores:—

R.A.M.C.

A. H. Heslop, lbw, b Charlton	2
Lieut. Gordon, b Charlton	20
Capt. Greenwood, c Farr, b Charlton	4
Major Cockrane, c Montgomery, b Kahlenberg	31
Capt. Churton, b Charlton	6
Lieut. Fish, b Charlton	9
Sergt. Steek, st Montgomery, b Charlton	47
Capt. Macpherson, c Charlton, b Tooth	13
J. C. Hart, b Tooth	5
Pte. Sinclair, b Tooth	0
Capt. Keble, not out	0
Extras	15
Total	152

GUY'S.

M. M. Munden, b Hart	74
C. H. Medlock, c Gordon, b Keble	6
R. Montgomery, c Cockrane, b Fish	71
N. E. Farr, b Fish	13
J. H. Clapperton, b Fish	31
P. C. Charlton, b Keble	50
W. Ingram, c and b Hart	0
W. T. Clarke, not out	48
F. C. Hunôt, b Cockrane	1
F. Kahlenberg, c Churton, b Cockrane	2
F. Tooth, not out	34
Extras	24
Total for 9 wickets	354

GUY'S v. TUNBRIDGE WELLS.

Played at Tunbridge Wells on June 3rd, and a very low scoring game ended in a win for the Hospital by 4 runs.

GUY'S.

M. M. Munden, c & b Elliot	25
C. H. Medlock, lbw, b Elliot	6
H. Lee, c Braybrooke, b Elliot	3
R. Montgomery, c Curtis, b Elliot	1
P. C. Charlton, st Curtis, b Wingham	21
N. E. Farr, ht wkt, b Wingham	4
F. C. Hunôt, b Wingham	4
J. H. Clapperton, b Elliot	0
A. C. Hancock, c Braybrooke, b Elliot	3
F. Kahlenberg, run out	8
F. Tooth, not out	2
Extras	4
Total	81

TUNBRIDGE WELLS.

J. H. Kelsey, b Charlton	3
R. Bryant, c Lee, b Kahlenberg	6
Wingham, c Munden, b Charlton	2
H. Braybrooke, c Lee, b Kahlenberg	26
J. Curtis, b Tooth	9
M. Bethindge, b Charlton	3
Maj. Spins, b Charlton	0
F. R. Curry, c Lee, b Kahlenberg	4
C. Elliot, not out	12
T. Bethindge, lbw, b Charlton	2
Dr. Thurlow, b Charlton	5
Extras	5
Total	77

GUY'S v. THESPIDS.

Played at Honor Oak Park on June 6th, and ended in an easy win for the Hospital. The Thespids won the toss, and sent us in to bat. Munden, Charlton and Montgomery all batted well for the Hospital, as did Bleachley and Egerton for the Thespids.

GUY'S.

M. M. Munden, c Hall, b Humphrys	131
C. H. Medlock, b Foster	12
R. Montgomery, run out	40
P. C. Charlton, c Hall, b Douglas	48
A. H. Birks, b Lane	15
F. D. Saner, not out	35
N. E. Farr, not out	24
Extras	51
Total (for 5 wickets)	356

Clarke, Clapperton, Kahlenberg and Tooth did not bat.

THESPIDS.

H. Lane, b Kahlenburg...	0
L. Holland, lbw, b Charlton	20
B. S. Foster, c Birks, b Kahlenburg	0
V. Conner, b Charlton	6
H. Bleachley, b Clapperton	43
B. Egerton, not out	29
H. Bracehall, b Tooth	10
C. Brooke, b Tooth	2
B. Humphrys, b Clapperton	5
F. C. Hunôt, c Farr, b Clapperton	8
— Knox, absent	0
Extras	16
Total	139

GUY'S v. CROFTON PARK.

Played at Honor Oak Park on Whit Monday, and ended in a win for the Hospital by 40 runs.

CROFTON PARK.

A. Partridge, c Scott, b Kahlenberg	4
B. Knight, b Clapperton	4
E. J. Cotton, c Clapperton, b Tooth	25
W. Hone, c Chapple, b Kahlenberg	7
T. Theobalds, run out	7
R. Barr, c Scott, b Kahlenberg	3
E. Glass, c Kahlenberg, b Tooth	0
P. Tuns, c Clapperton, b Kahlenberg...	1
J. J. Mansell, c Montgomery, b Tooth	9
E. J. Sewell, c Clapperton, b Kahlenberg	3
C. Brown, not out	3
Extras	4
Total	70

GUY'S.

C. H. Medlock, b Brown	16
N. E. Farr, b Cotton	3
M. M. Munden, run out...	17
R. Montgomery, b Cotton	14
H. Chapple, b Brown	7
F. D. Saner, b Cotton	1
W. T. Clarke, c Brown, b Cotton	6
M. Scott, b Cotton	3
J. H. Clapperton, c and b Barr	9
F. Kahlenberg, c Tuns, b Barr	23
F. Tooth, not out...	0
Extras	11
Total	110

Lawn Tennis.

1ST VI. v. DULWICH FARM.

This match took place at Dulwich on Wednesday, May 27th, and resulted in a draw, three matches each. Our opponents did not turn up till six o'clock, so we were unable to finish. F. T. Cutler was unavoidably detained at the last minute. Result :—

H. Chapple and H. Sharpe lost to Martin and Philpot, 2-6, 8-6, 2-6; beat Twigg and Hill, 6-4, 6-2. M. M. Adams and G. H. Hunt lost to Twigg and Hill, 10-8, 3-6, 4-6; beat Garnet and Garnet, 6-3, 6-2. R. Curle and G. C. Covell lost to Martin and Philpot, 3-6, 3-6; beat Garnet and Garnet, 11-9, 5-7, 7-5.

1ST VI. v. SURBITON "A."

This match took place at Surbiton on Saturday, May 30th, and resulted in a win for the Hospital by 5 matches to 4. F. T. Cutler and R. Curle won their three matches, each match running into three sets. M. M. Adams and G. C. Covell won two matches, whilst M. M. Earle and H. Sharpe lost all their three. Result: —

F. T. Cutler and R. Curle beat T. S. Bell and A. L. Wilson, 7-5, 4-6, 6-2; beat T. E. Dawes and N. C. Carver, 6-3, 1-6, 6-2; beat T. Albert and C. Beaumont, 6-2, 6-8, 7-5. M. M. Adams and G. C. Covell lost to T. S. Bell and A. L. Wilson, 4-6, 3-6; beat T. E. Dawes and N. C. Carver, 6-1, 2-6, 6-2; beat T. Albert and C. Beaumont, 6-3, 6-0. M. M. Earle and H. Sharpe lost to T. S. Bell and A. L. Wilson, 3-6, 3-6; lost to T. E. Dawes and N. C. Carver, 6-3, 6-8, 3-6; lost to T. Albert and C. Beaumont. 6-2, 6-8, 5-7.

1ST VI. v. FINCHLEY.

This match took place at Honor Oak Park on Saturday, June 6th, and resulted in a win for the Hospital by 7 matches to 2.

Finchley were unable to bring their usual first pair, unfortunately for those who did come, for H. Chapple, finding some of his old form, played brilliantly, and practically won his three matches by himself, needing very little help from his partner. F. T. Cutler, who throughout the season has shown such consistent good form, played with his usual steadiness and accuracy. Result :—

H. Chapple and H. Sharpe beat A. Wiltshire and T. E. Alexander, 6-2, 7-5; beat C. S. Tukes and A. C. Tannahill, 6-1, 6-1; beat W. W. Weller and A. C. Kelly, 6-2, 6-3. F. T. Cutler and R. Curle beat A. Wiltshire and T. E. Alexander, 4-6, 6-2, 6-2; beat C. S. Tukes and A. C. Tannahill, 6-2, 7-5; beat W. W. Wellar and A. C. Kelly, 6-3, 9-7. M. M. Earle and E. Billing lost to A. Wiltshire and T. E. Alexander, 6-8, 4-6: lost to C. S. Tukes and H. C. Tannahill, 2-6, 0-6; beat W. W. Wellar and A. C. Kelly, 6-4, 3-6, 6-3.

Rifle Association.

FIXTURES.

Wed., June 17.—G.H.R.A. Prize Meeting.

Tues., June 23.—Match v. Epsom School (shot at Dorking).

Wed., June 24.—4th Armitage shoot.
United Hospitals' Prize Meeting.
Simultaneous matches v. Cheltenham and Tonbridge.

SECOND ARMITAGE SHOOT.

This match took place on May 27th. We were not at full strength, two regular members of the team being unable to shoot. Mary's score of 557 is a record for the competition, the former best having been 529 made by Guy's last year. Scores :—Guy's :

W. E. Wallis	94	M. K. Nelson	75
L. L. C. Reynolds ...	90	W. Robinson	58
H. L. Attwater ...	89		
C. C. Holman	87		493

Mary's, 557. Bart.'s, 504. Thomas's, 423.

May 27th.—United Hospitals v. North London Rifle Club, 2nd class shoot. Shot at Bisley. N.L.R.C., 742; U.H.R.C., 708. Wallis 94, and Attwater 89, were the scores of the Guy's men.

June 6th.—United Hospitals v. R.M.C., Sandhurst. Shot at Sandhurst. U.H.R.C., 696; R.M.C., 656. Last year this match was lost by three points.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

June.

Sat. 27. 1st XI. v. Granville (Lee) (Home).

Mon. 29. Special Clinical Lecture by Mr. Fagge (Otology) at 1.15 p.m.
Water Polo v. City Police (Home).
Going-off Dinner, 7 o'clock in Dining Hall.

July.

Wed. 1. 2nd XI. v. Crofton Park (Home).
August Appointment List opened (Medical).
October Appointment List opened (Dental).

Thur. 2. Mr. Lane's and Mr. Fagge's Take-in commences (Messrs. Dryland and Carlyll).
2nd Conjoint commences.
1st Test Examination (Dental Metallurgy).

Sat. 4. 1st XI. v. Wanderers (Home).
2nd XI v. Sidcup College (Away).

Mon. 6. Special Clinical Lecture by Mr. G. Bellingham Smith (Gynæcology) at 1.15 p.m.
Inter. M.B. (Lond.) and M.D. and M.S. Lond. Exams. commence.

Tues. 7. Final Conjoint begins.

Wed. 8. Garden Party.
Biennial Dinner in the evening.

Thur. 9. Mr. Dunn's and Mr. Rowland's Take-in commences (Messrs. Hinde and Ewing).

Fri. 10. 1st Test Exam., Dental Mechanics, at 2.30 p.m.
Test Exam. for Final L.D.S.
Water Polo v. Nautilus (Home).

Passim.

AT a recent meeting of the General Court, His Grace the Duke of Sutherland, K.G., was unanimously elected a Governor of the Hospital. Guy's is to be congratulated on adding to its already distinguished list of Governors, the name of His Grace. His practical interest in schemes philanthropic is too well known to need comment.

THE Annual Garden Party and Presentation of Prizes is to be held on Wednesday, July 8th. Given a fine day, this function will be a huge success. The Right Hon. Lord Rothschild, G.C.V.O., has kindly consented to distribute the prizes, and the gathering will include many distinguished personages. The Governors and Staff of the Medical School will assemble in the Court Room at 3 p.m. to meet Lord Rothschild, and they will then proceed to the Physiology Theatre. The Treasurer, Mr. Cosmo Bonsor, will take the chair at 3.15 p.m., and the Dean will read his annual report. Lord Rothschild will then distribute the prizes, and afterwards deliver an address. Dr. Hale White is to propose the vote of thanks to Lord Rothschild; this will be seconded by Mr. Golding-Bird. The whole of the Hospital, College, Library, Museum, Nurses' Home and School Buildings will be thrown open for inspection. Refreshments, as usual, will be served in the colonnade quadrangles and on the terrace in the Park. Music is to be provided, this year, by the Royal Meister Orchestra, under M. Eugène Maney, who will play a most attractive programme.

THIS year's function should be a memorable one in many ways. The unique financial position of the hospital, the successes of the School, the prospects of the early realisation of the schemes

now before the Governors, and the final appearance (as such) of our senior surgeon, Mr. Golding-Bird, all tend to give *éclat* to the occasion. We trust that all those men who are able, will attend the distribution, and will seize upon this opportunity of giving Mr. Golding-Bird a rousing welcome. The park itself is in splendid condition, and Jimmy and his assistants deserve great praise. The road improvement in front of Hunt's building is almost completed, and though at present it is unpleasantly reminiscent of London County Council efforts in the Strand in mid-season, the ultimate benefit will be great. The new building, Newcomen Street way, is progressing apace, and we have no doubt the authorities will in some way veil the uncompleted front which presents on approaching from the Surgical block.

For the sake of the old Guy's men who always make this function the occasion of an annual visit, the new things to see are the Medical Skiagraphy Department and the Eye Ward improvements, with special reference to the Operating Theatres.

In the evening of the 8th July takes place that great *réunion*, the Biennial Dinner. On another page will be seen a list of those who have already promised to be present. Many of your old colleagues are sure to be amongst them, so do not delay, but write to the Hon. Secretary at once. Arrangements, we hear, are progressing admirably, so that we feel certain a very pleasant evening will ensue. Present men should not hesitate because the majority of the diners will be "before their time," for there will be a big scattering of men they know there.

The annual election to the Council of the Royal College of Surgeons takes place on July 2nd. The retiring members are Mr. A. Pearce Gould, Mr. J. Cousins, and Mr. Harrison Cripps. Prof. Howard Marsh is also retiring. There are four vacancies, and the full list of candidates is eight, amongst which are the names of two Guy's men—Mr. George Eastes, who is standing as "a representative of general practitioners," and Mr. Arbuthnot Lane. We hope all old Guy's men eligible to vote, will bear them in mind, and we wish the candidates every success.

On Monday evening last, there was held at the Southwark Baths the most successful entertainment the Swimming Club have yet given. The energy of the Hon. Secretary, Mr. P. S. Price, and the other officials, was well rewarded by the appreciation one heard on all sides, and great credit is due to the organisers, not only for providing such an excellent programme, but also for the admirable manner in which it was carried out. There was not a single hitch from beginning to end. To the keenness of the popular and much-respected President, Sir Alfred Fripp, the Club owes no small portion of the success. Throughout the whole of the present session he has been indefatigable in his efforts to ensure that this year's display would eclipse all records. He was instrumental in persuading Lady Constance Stewart Richardson and Miss Ada Lewin to attend and delight the audience with an exhibition of diving and swimming such as one seldom has the good fortune to see. The elegance and grace of Lady Constance's finished performance was a revelation to most present, and the reception which it met with must have been flattering even to such a well-known and popular amateur. In no less a measure was appreciated the magnificent diving of Messrs. Melville Clarke, Grimswade, and Hughes. The first-named was National Champion for three successive years: he retired from the active list two years ago. Messrs. Grimswade and Hughes, we hear, are competing at the Olympic Games —we wish them every success.

The Matron very kindly gave permission for the nurses to take part in the Ladies' Invitation Race, and nine members of the nursing staff did so. We congratulate them on their sporting spirit, and only regret that there was not a prize for each of them. We are requested by the officials of the club to express their thanks to the ladies and gentlemen who, by their good nature and skill, helped to make the evening the great success it was. Sir Alfred Fripp, in his speech, referred to the kindness of Lady Constance Stewart Richardson, and this all

present heartily endorsed. To the prize-givers we also extend, on behalf of the committee, the most cordial thanks.

GUY'S men are scattered to the four corners of the Globe, but we have not as yet a representative in the Arctic Circle. Dr. James F. Rymer, son of Alderman S. L. Rymer, of Croydon, who has for some time past been living in Canada, is about to take up his residence at Fort Good Hope. He proposes staying in this part for at least three years, and giving medical and surgical treatment to the Indians and Esquimaux in the vicinity of Forts Good Hope and Macpherson. We trust he escapes the wary wiles of the walrus and the solicitous embrace of the Polar bear, and that his courage will be rewarded by good results.

THE Sixth South African Civil Surgeons' Dinner will take place on Friday, July 24th, at 7.45 p.m., at the Imperial Restaurant, Regent Street. The Right Hon. R. B. Haldane, M.P., Secretary of State for War, has kindly consented to be present, and the Chair will be taken by Anthony A. Bowlby, Esq., C.M.G. Reply cards have been sent to those whose addresses are available, and it is hoped that those who wish to attend will reply as soon as possible. Old South African Civil Surgeons, to whom notices have been sent and who would like to be present, are requested to communicate with C. G. Watson, Esq., 44, Welbeck Street, W. The price of the dinner will be 10s. 6d., exclusive of wine.

MR. HUGHES, who is warded in Astley-Cooper, owing to a septic arm, is, we are pleased to hear, progressing slowly, but surely. Mr. Turner is carrying on the duties of R.S.O. in Mr. Hughes' absence.

A NUMBER of Guy's men made a journey to Earlswood last week, and paid the asylum a visit. Whilst waiting for a train on their return, one of the members of the party, a camera fiend, grouped the men and snapped them. On developing the plate and taking a print, he found that he had not been too fortunate in his choice of a background, for behind the group was a huge board, "Earlswood Home for Imbeciles, etc." He showed a print to one of the nursing staff; she looked at it with interest, then a smile of pity stole over her face as she read the inscription in the background, and she murmured in a commiserating tone, "Oh! the poor things." If that camera enthusiast does not suppress that print, we can see him losing a lot of his popularity amongst his friends.

ONCE again is a hospital society indebted to Mr. R. M. Wingent for his ever-ready acquiescence to assist with his talented brush. The design on the programme of the Swimming Club's entertainment called forth much admiration, and was instrumental in ensuring a sale which was of no little financial assistance to this society.

IT was indeed satisfactory to find the Physiology Theatre so well filled on the occasion of Prof. Fulgence Raymond's clinique, which the learned and popular Parisian savant held at 11 a.m. yesterday (Friday). Men of all years were there, a good scattering of Graduates, and many members of the Staff, amongst others, Sir Cooper Perry, Dr. Hale White, Dr. Pitt, Dr. Shaw, Mr. Eason, Mr. Ormond, Mr. Rowlands, and most of the Junior Staff. The learned Professor proceeded, after a short tribute to distinguished English neurologists, to demonstrate, in his own charming manner, four cases from the wards. The first case was, appropriately enough, one of "pied de Charcot;" for, as the Professor informed us, he was Charcot's "interne" when the great French neurologist first described the condition in 1868. The second case, which he thought had a tubercular origin, and which many of those who have seen it in the ward thought to be one of disseminated sclerosis, called forth a remark which, in its directness, caused some amusement. In speaking of the operative treatment he said: "Prenons-garde avant de passer la main au chirugien d'avoir essayé toutes les méthodes dont nous disposons; car, alors, l'avenir du malade devient trés incertain." The demonstrations of the third and fourth cases were unfortunately somewhat curtailed owing to lack of time; one point, however, the treatment of syringo-myelia by X-rays, was new to most of us. The success which Professor Raymond has had with it, opens up a new field, and we trust that it will be given extensive trial with any cases which come into Guy's. Suggestion is now used in diagnosing hysteria on the Continent, and Professor Raymond outlined it in the fourth case. Our thanks are due to our distinguished visitor for giving us such a treat, and we trust that on a future occasion we will again have an opportunity of seeing him. No less are we indebted to Dr. Hertz, for to him the credit of the Professor's appearance at Guy's is due.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Biennial Dinner, 1908.

DEAR MR. EDITOR,—Many thanks for your help in making announcements as to the Biennial Dinner. I am glad to tell you that, if all those who have sent in their names are able to come to the dinner, we shall have the largest muster since 1860, before which date records are not available. The record attendance was in 1872, under the chairmanship of Dr. Habershon, when 289 Guy's men dined together. This large prospective attendance need cause no anxiety as to overcrowding, for I am assured that the room in which we are to dine will comfortably accommodate 500. I should, therefore, be only too pleased to receive further applications from any Guy's men who, perusing the final list, which I hope you will be kind enough to publish to-day, find therein the names of friends whom they would like to meet. Any names reaching me by the first post on Monday morning next will be included in the list which will be sent round with the tickets in order to enable diners to choose their table companions. These lists, with the dinner tickets, will be posted so as to be delivered on Wednesday, July 1st, and I would most earnestly ask all diners to send the form, duly filled up, back to me by return of post. If this is done, I am hopeful of being able to arrange that every man will find himself surrounded by his best friends.

I am, yours sincerely,

LAURISTON E. SHAW,

64, Harley St., S.W. Hon. Sec.

P.S.—The date of the dinner is Wednesday, July 8th, and applications for tickets can be received up to the first post on Saturday, July 4th, but not later.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants.—Messrs. M. E. Ball, A. W. Ewing, E. L. Martyn Lobb, H. E. Perkins, H. A. Sanford, St. J. A. M. Tolhurst.

Clinical Assistant in Medical Out-patients.—Mr. D. Allan (Drs. Fawcett and French).

Dressers in the Throat Department.—Messrs. E. R. Stone, J. Walker, L. W. Evans.

Medical Ward Clerks.—(Extensions) Messrs. C. Witts, W. Reynolds (Dr. Hale White); F. S. D. Berry, B. McDermott (Dr. Pitt); M. A. E. Duvivier, R. P. Ballard, N. Reader (Sir Cooper Perry); G. H. Hunt, J. H. Owen (Dr. Shaw). J. Pryce Davies, G. B. Cockrem, W. H. Talfourd Jones, T. T. O'Callaghan, M. M. Munden, E. A. Penny, F. A. Dick, G. Dunderdale, G. Maxted, C E. Reckitt, M. C. Thavara, G. Y. Thomson, T. Lewis Jones, J. A. Edmonds, A. L. Saul, W. E. Fox, W. E. Levinson, H. F. Stephens, R. Montgomery, H. F. Renton, G. E. Warner Lacey, A. D. Vazquez.

Surgical Ward Clerks.—Messrs. R. Stout, A. Stanley Roe.

Assistant Surgeons' Dressers.—Messrs. F. S. Adams, H. W. Doll (Sir Alfred Fripp); W. T. Chaning-Pearce, K. T. Khong, J. W. Williams (Mr. Steward); A. Neville Cox, J. G. Saner, H. Gardner (Mr. Fagge); H. G. Rice, D. C. Lloyd, T. D. M. Stout (Mr. Rowlands).

Assistant Surgeon's Clerk.—Mr. W. H. Talfourd Jones (Mr. Rowlands).

Post-Mortem Clerk.—Mr. A. C. Schulenberg (July—September).

Aural Surgeon's Dresser.—Mr. L. W. Evans.

Obstetric Dressers.—(July–August) Messrs. D. Reynolds, C. F. Searle (Dr. Horrocks); A. H. Crook (Mr. Targett).

Civil.

BUSH, W. H., L.S.A., has been appointed District Medical Officer, Flaxton (Out-relief) Union.

CLOWES, E. F., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Charfield District by the Thornbury (Gloucestershire) Board of Guardians.

GREENFIELD, DUDLEY G., M.D. Lond., F.R.C.S. Eng., has been appointed District Medical Officer of the Wellingborough Union.

Naval and Military.

The following appointments have been notified at the Admiralty:- Fleet Surgeon HORACE B. MARRIOTT, R.N., to the *Doris*, on recommissioning; Surgeon ROBERT W. B. HALL, R.N., to the *Cormorant*, additional for Gibraltar Dockyard; and Surgeon R. WILLAN, R.N., to the *President*, additional for the *Maine*.

R.A.M.C. (Militia). Captain W. K. STEELE is promoted to be Major.

Notices.

His Majesty's Indian Medical Service.

A competitive examination for not less than twenty appointments to His Majesty's Indian Medical Service will be held at the Royal Army Medical College, Millbank, S.W., and at the Examination Hall, Victoria Embankment, London, on the 27th July, 1908, and five following days. Copies of Regulations for the examination, together with information regarding the pay, retired pay, etc., of Indian Medical Officers, can be obtained on application to the Military Secretary, India Office, London, S.W. Application for admission to the examination, with the necessary certificates, must be sent so as to reach him on or before the 14th July, 1908.

Clubs' Union.

Annual Report, 1907—1908.

The Council of the Clubs' Union beg to present their Sixteenth Annual Report of the progress of the Union, together with a statement of the Receipts and Expenditure for the year ending 31st March, 1908.

The total Membership of the Union now stands at 2,668, of whom 2,255 are Life Members, 372 Annual Subscribers, 33 Patrons, and 8 Honorary Members; 74 new members joined the Union last year.

An attempt has been made this year to make the Blue Book of the Union of greater interest. With this object in view, pages have been introduced containing notes of the doings of old Guy's men, and a card is being sent out with the book to all Life Members in order that the Club List may be revised, and that notes may be obtained of naval, military, and civil appointments, university and other distinctions obtained during the present year.

It is hoped that Members all over the world will make the Year Book a success by filling in such details and returning the card to the Secretary.

The financial condition of the Union continues to be satisfactory. As a result of last year's working, income exceeded expenditure by about £240. Of this sum £100 has been transferred to the Reserve Fund which was established last year for the purpose of meeting depreciation, which fund now stands at £150, the Council feeling that within a short time it will be necessary to call upon this reserve. A further sum of £100 is being utilised to pay off some of the outstanding liability, amounting to £500, which bears interest at 4 per cent.

The accounts have, as usual, been audited by a firm of chartered accountants.

The best thanks of the Council are due to the Officers of the Constituent Institutions, to the Auditors of the accounts of the several clubs, to Mr. Mills, the Librarian, and to Mr. Croucher, for their assistance.

(Signed) F. J. STEWARD,
June, 1907. Chairman.

Revenue Account for the Year ending 31st March, 1908.

EXPENDITURE.

Dr.	£ s. d.	£ s. d.
To Grants to Constituent Institutions—		
Rifle Club	13 12 2	
Rugby Football Club ...	22 9 8	
Association Football Club...	13 11 2	
Athletic Club	42 0 0	
Cricket Club £18 0 0		
Less over-estimated in 1907 4 0 0		
	14 0 0	
Lawn Tennis Club £11 8 10		
Add under-estimated in 1907 0 14 5		
	12 3 3	
Hockey Club...	3 0 0	
Physical Society	17 11 4	
Guy's Hospital Gazette ...	109 0 0	
Students' Club	150 15 10	
Swimming Club	5 5 2	
Dental Society	9 15 11	
Debating Society	8 9 10	
Prayer Union	3 0 0	
		424 14 4
To Students' Club Rent...		171 10 6
„ Production of Year Book		79 18 2
„ „ of Reports		95 0 0
„ Field Current Expenses		329 12 9
„ Rates, Taxes, Water, and Insurance		70 2 5
„ Field Rent Account		218 10 0
„ Secretarial Expenses		44 6 9
„ Printing and Stationery		12 5 6
„ Sundry Disbursements		2 5 0
„ Auditors' Fees		5 5 0
„ Gazette Postages		8 10 0
„ Balance, being excess of Income over Expenditure		248 19 3
		£1,710 19 8

INCOME.

Cr.	£ s. d.	£ s. d.
By Subscriptions	1,184 18 6	
„ „ from Patrons ...	16 11 0	
„ „ for Short Periods	6 6 0	
„ Gazette Committee, being agreed proportion of Subscriptions for Gazette and Reports	76 11 5	
		1,284 6 11
„ Sundry Receipts—		
Grant from Medical School ...		200 0 0
„ Dental School... ...		20 0 0
Rent from Tenants		90 0 0
„ Lockers		8 15 0
Year Book Advertisements ...		43 13 0
Gate Receipts	73 16 10	
Less paid to Gazette Committee on account of Loan £11 13 4		
Amount due R. Rist 12 2 9		
	23 16 1	
		50 0 9
Sale of Season Tickets		0 10 0
Deposit Interest		13 14 0
		£1,710 19 8

Appointments.

House Physicians.—Messrs. B. H. Palmer (Dr. Pitt); E. P. H. Joynt (Dr. Shaw).

House Surgeons.—Messrs. G. W. Dryland (Mr. Lane); E. B. Hinde (Mr. Dunn).

Out-Patient Officers.—Messrs. Chase, Cook, Henderson, Syms.

Assistant House Surgeons.—Messrs. H. Sandford (Sir A. Fripp); A. Tolhurst (Mr. Steward); H. B. Carlyll (Mr. Fagge); A. W. Ewing (Mr. Rowlands).

Obstetric Resident.—Mr. C. B. Ticehurst.

Guy's Hospital Biennial Dinner, July 8th, 1908.

List of those attending—Names sent in before Wednesday, June 24th.

Qualified between 1849—1868.

T. Bryant
C. Holman
H. J. Thorp
F. W. Pavy
J. Rand
J. Tanner
A. Roper
P. Minns
H. A. Martin
W. Soper
T. Stevenson
P. H. Pye-Smith
R. T. Nichols
G. H. Savage
F. Manser
G. Eastes
T. P. Warren
R. Elphinstone
J. R. Bosworth
C. Sangster
B. N. Dalton
F. Taylor
R. Bowen Hogg
C. Higgens
J. F. Goodhart

1869—1878.

T. S. Townsend
A. Gillingham
G. W. Shipman
W. B. Taylor
F. Durham
G. J. Congdon
W. H. Jalland
S. Murphy
H. R. Ker
J. H. Ewart
E. G. Younger
W. A. Brailey
C. H. Golding-Bird
A. L. Galabin
C. J. W. Pinching
W. J. Tyson
W. J. Heddy
H. F. Lancaster
T. Brown
A. de W. Baker
D. Elcum
St. C. B. Shadwell
C. J. Symonds
G. Mackern
W. E. Dring
L. Bowen-Jones
J. Mackern
H. Davy
L. W. Reynolds
C. K. Shaw
J. T. Gardner
W. L. Chubb
W. A. Lane
W. F. Hearnden
R. J. Bryden
E. C. Beale

1879—1888.

T. A. I. Howell
W. Hale White
E. J. Morley
C. J. Harper
G. Steele-Perkins
J. F. Briscoe
F. W. Pilkington
P. Warner
F. Newland-Pedley
J. M. Owen
T. R. Atkinson
E. L. Adeney
P. H. Gardner
R. A. Milligan
H. Blatherwick
B. Scott
E. W. L. Stephens
J. Fraser
S. Worthington
H. P. Berry
G. A. Johnson
J. H. Gibson
J. A. P. Price
F. W. Cock
L. A. Dunn
A. J. Dalton
J. H. Targett
R. Cuff
W. R. Dakin
L. E. Shaw
C. D. Muspratt
A. E. Kinsey-Taylor
G. F. Hugill
S. H. Agar
A. H. Tubby
R. M. H. Randell
R. W. Brogden
H. E. Counsell
A. J. Carter
W. A. Maggs
G. N. Pitt
E. W. Goodall
A. E. Price
H. Lund
H. Hore
S. Wacher
F. R. B. Bisshopp
H. M. Page
E. Cooper Perry
E. C. Greenwood
F. F. Burghard
F. Beard
G. Rowell
A. S. Taylor
H. M. Brownfield
E. M. Hearnden
C. F. Routh
P. N. Randall
R. Capes
G. Black
R. D. Mothersole
J. D. Cruickshank
W. C. Swayne

1889—1898.

H. J. Holman
R. W. Rouw
J. P. Pendlebury
R. G. P. Lansdown
T. G. Stevens
F. Vicars
W. J. Scott
G. W. B. Featherstone
B. W. Hogarth
J. Fawcett
F. C. Young
J. Young
A. M. Daldy
D. W. Samways
J. W. F. Jewell
W. E. S. Cobb
M. Craig
M. F. Hopson
C. G. Roberts
E. E. B. Landon
J. D. Thomas
T. D. Lister
W. H. Fisher
W. Carling
W. Bligh
G. Pender-Smith
H. C. Sharp
F. P. S. Cresswell
A. Shillitoe
H. Cooper
W. R. Grove
J. Eyre
F. H. Edwards
J. J. E. Biggs
H. M. Stewart
A. P. Beddard
H. A. Duffett
G. S. Hovenden
F. J. Steward
E. G. Little
E. A. Peters
A. Allport
H. A. Munro
A. P. Allan
E. R. Fothergill
E. T. Shorland
P. F. Henry
W. H. Peake
A. H. Partridge
E. I. Spriggs
G. Burton-Brown
E. Fisk
G. B. Muriel
W. Tyson
C. H. Fagge
J. H. Busteed
M. Aston-Key
R. H. Ashwin
A. W. Ormond
W. I. Hancock
W. R. Cazenove
R. P. Rowlands
H. J. Spon
W. E. Hills
C. D. Edwards
C. H. Knowles
F. Fremantle
A. J. Cleveland
P. Turner
M. Way
C. E. Michael
R. W. Mayston
R. B. Stamford
A. E. Porter
E. W. S. Rowland
H. L. Eason
W. J. Henson
R. H. J. Swan
R. Balderston
G. C. Owsley
G. N. Mottram

1899—1908.

H. E. C. Fox
L. McGavin
A. A. Miller
J. L. Payne
J. B. Walters
F. E. Walker
O. Marriott
D. Forsyth
T. P. Thomas
F. C. Wetherell
R. Thompson
W. H. Bowen
E. J. F. Hardenberg
F. G. Cross
H. K. Lacey
F. D. S. Jackson
F. Shipway
O. W. Richards
C. Pinching
B. Glendining
A. R. Brailey
H. W. Bethell
H. C. C. Mann
E. C. Hughes
W. M. Mollison
E. W. Routley
H. M. Woodward
A. F. Hertz
W. N. May
B. H. Stewart
A. H. Miller
H. C. Cameron
H. A. Watney
E. W. Sheaf
A. D. Crofts
P. C. Litchfield
H. D. Wyatt
C. F. Fothergill
A. S. M. Palmer
T. B. Layton
L. G. Davis
H. F. Vandermin
R. Davies-Colley
J. H. Ryffell
P. P. Laidlaw
G. W. Goodhart
E. L. Norton,
J. N. Watson
G. F. Stebbing
W. W. Cook
A. T. Densham
M. A. Rahman
C. H. Rippmann
H. O. Brookhouse
N. Flower
L. Mandel
R. C. H. Francis
P. C. Field

H. Cosmo Bonsor, Sir Cameron Gull, Mr. R. C. G. Hoare, Dr. A. H. Fison, Mr. C. E. Groves.

A Curious Case of Tracheal Obstruction, ending Fatally.

From the Surrey Dispensary. By E. P. MINETT, Resident Medical Officer.

A child, æt. 3 years, was treated at Out-patients, and, subsequently, at home, for broncho-pneumonia, which was localised chiefly in the right side of thorax. The case ran an ordinary course, and apparently cleared up satisfactorily, leaving, however, a chronic cough, somewhat difficult to deal with. Four months later, the child was brought up to Out-patients, on a Monday, with the complaint that it had suddenly become "blue," and had a violent attack of coughing and dyspnœa, lasting about twenty minutes. On examination, the child was fairly well-nourished, and did not show any urgent symptoms. The heart sounds were normal, and the impulse was in the nipple line. The right lower and middle lobes of the lung were dull in patches, on percussion, but the upper right lobe and left side of thorax gave a good note. T. V. F. was well marked on the right lower side of thorax, and, curiously enough, well-marked also over the left base. On auscultation a few scattered râles were heard all over the right lung area, and a few loose "bubbling" râles at the left base. The breath sounds were increased at the right apex, and audible, but very irregular, over middle and lower lobes. On the left side, the breath sounds were practically absent at the base, and only very faintly heard over the upper lobe, being markedly diminished over the left bronchus at the bifurcation of the trachea as compared with the right bronchus, where they were accentuated. Temperature, pulse, and respiration were normal.

As no signs of tubercular disease, glands, growths, etc., could be made out as likely to account for the apparent obstruction to left bronchus, the child was given a simple cough mixture, M. Oxymel, and ordered to attend again on Thursday following.

Two days later, at 11.30 p.m., the Resident Medical Officer was sent for, the message being that the child was "black in the face and quite lifeless." On arrival, I found what I considered to be a normal child, no dyspnœa, no dilated pupils, and the mouth, fauces, and tonsils perfectly normal, temperature normal, respiration normal, but pulse rapid and irregular, and thus, with the exception of the physical signs noted above, nothing abnormal was observed to account for the sudden attack of dyspnœa. At 4.0 a.m., roughly four hours later, the father came to say the child was dead. As I could not account for this sudden death, on consultation with the Staff Physician, who had seen the child on the Monday, a certificate was refused.

Post-mortem examination showed the child to be perfectly normal in every respect, with the exception of the thorax. Both lungs were engorged with blood, pulmonary artery full, right side of heart full, and left empty; small hæmorrhages were seen on surface of pleura and in lung substance, and the signs of old broncho-pneumonia well marked in right side. But on opening the trachea itself a small horse-bean was found lodged in the trachea, about a quarter of an inch above the bifurcation; and at the orifice of the left bronchus was found a depressed patch of necrosis, extending down to the cartilage, which was exactly the size of the bean, surrounded by an area above and below of injected and inflamed tracheal lining. As the place where the bean was actually found was fairly normal, and free from signs of pressure or necrosis, it is evident that the bean must have lodged in the opening of the left bronchus for days at the necrosed area, and on the occasions of dyspnœa complained of, been temporarily coughed up into the trachea, slipping back later into the left bronchus, except on the final occasion, when, presumably, it caused sufficient laryngeal obstruction and spasms to bring on asphyxia.

Annual Swimming Sports.

A Highly Successful Evening.

The Annual Sports of the Swimming Club were held at the Southwark Baths on Monday evening last, 22nd June. The attendance was a record one, and we were pleased to see amongst the audience many members of the Staff. There was a goodly number of the nursing staff present, whilst the men turned up in force.

Amongst those present we noticed Lady Perry, Lady Fripp, Dr. and Mrs. Hale White, Mrs. Lane, Mrs. Fagge, Mr. Lewin Payne, and many members of the junior staff.

The honorary secretary, Mr. P. S. Price, is to be congratulated heartily on the excellence of the programme and the management of the whole proceedings. We can recall no more enjoyable swimming display. The high standard of the programme was to a great extent due to the great kindness of Lady Constance Stewart Richardson, Miss Ada Lewin, and those three excellent sportsmen, Messrs. Melville Clarke, Grimswade and Hughes, all of whom, at some inconvenience to themselves, turned up. It is needless for us to comment upon Lady Stewart Richardson's exhibition—her skill is so well known. At the Bath Club this charming performer has the advantage of the apparatus which this bath possesses—trapeze and rings—and her display there is more elaborate. What it is like all present can guess, for elegance and grace were personified in the several feats she performed.

Miss Ada Lewin, the Instructress at the Bath Club, also gave us a most finished display. The torpedo and walking on the floor of the bath evoked much applause; every feat was done with such effortless grace that we probably shall have torpedo and fish acts all the vogue in the Nurses' Bath for some time to come.

The nurses, whom we congratulate on the sporting spirit they showed, opened the programme with a 66 yards

handicap. After the second heat there was not much doubt who would win, for Nurse Fletcher (with a very good turn of speed) showed excellent form, and in the final, in spite of her being on the scratch mark, she won easily.

The 66 Yards Final Scratch Race (the preliminary heats having been swum off on June 18th and 19th) was a ding-dong battle, and C. D. Roberts showed that in spite of lack of practice he retains his great speed. The time is fast, 43⅘ secs., and when we realize that not more than four feet separated the three competitors, we can see that the Hospital possesses three men considerably above the average amateur in Roberts, Glover, and York Moore.

Both the Long Plunge and Neat Dive were carried off by J. Pryce Davies. He beat H. J. Henderson in the Plunge by a foot. In the Neat Dive, which Mr. Melville Clarke, the ex-Amateur Champion, judged, Schlesinger, who was placed second, spoilt his chances by over-turning in his high dive; he was ill-advised to make it his voluntary as well.

The Quarter-Mile, for which three started, resolved itself into a race between Moberley and Pern, Hickman retiring early in the contest. The former has a magnificent stroke, and when extended should do better than 6 min. 58 secs.

The handicappers must have felt a glow of satisfaction when they witnessed the final of the 66 Yards Handicap, for Pritchard beat Glover by a touch, and between the four men there was barely five feet.

The display of diving by Messrs. Melville Clarke, H. J. Grimswade, and L. Hughes was a veritable treat. Though used to a platform fifteen feet higher they delighted the audience. The Standing Swallow Dive of Mr. Clarke, and the Running Swallow Dive of Mr. Hughes, were very popular. Mr. Grimswade's Back Somersault was very pretty, whilst the concerted dives of the three were the acme of judgment and skill. So keen were the nurses that their ardour was in no way damped by their proximity and frequent splashings; not even did Mr. Grimswade's honey-pot dive drive them rom their fastness.

The Obstacle Race was productive of much amusement, whilst in the Full Clothes Race we still think that the lady in the Directoire costume should have had a handicap.

The Polo Match, Past v. Present, was fast and furious. What the result would have been if Mr. Graham Marshall could have brought a full team we dread to think. As it was, he and Mr. A. Styer almost played the Present themselves, not that our men who assisted did not do their utmost, but from the fact that three of them had not played for some seasons, and that the other two were playing in unaccustomed positions.

Sir Alfred Fripp acted as Master of the Ceremonies, and carried the evening through with his well-known ability. To Sir Alfred the thanks of the club are due for the great practical interest he has displayed. It was a shortcoming on someone's part that three very lusty cheers were not given for him. Will he accept this appreciation instead? After the Polo Match Lady Stewart Richardson presented the prizes, and Sir Alfred thanked her in a pretty speech. The loud cheers which concluded the evening were some token of her popularity.

The officials were:—Judges, Sir Alfred Fripp, Dr. Allport, Messrs. Fagge, Steward, and Rowlands; Timekeeper: Mr. Graham Marshall; Stewards: Messrs. Ball, Eccles, Clarke, Pritchard, Rice, and Reeve. Results:—

LADIES' INVITATION RACE, 66 YARDS HANDICAP.—Heat 1: Nurse May, 2 secs. 1; Nurse Nixon, 7 secs. 2. Heat 2: Nurse Fletcher, scratch, 1; Nurse Miller, 4 secs. 2. Final: Nurse Fletcher, 1; Nurse May, 2.

66 YARDS (SCRATCH) FINAL.—C. D. Roberts, 1; H. Glover, 2; J. York Moore, 3. Won by three feet. Time, 43⅘ secs. (Prize presented by the President.)

LONG PLUNGE.—J. Pryce Davies, 50ft. 4in. 1; H. Henderson, 49ft. 4in., 2.

440 YARDS, SCRATCH.—A. Moberley, 1; M. Pern, 2. Won easily. Time, 6 min. 58 secs. (Prize presented by J. Lewin Payne, Esq.)

NEAT DIVING (2 dives from each height and one voluntary).—J. Pryce Davies, 1; J. Schlesinger, 2. (Prize presented by the GAZETTE.)

66 YARDS HANDICAP (Final).—G. B. Pritchard, 3 secs. start, 1; H. Glover, scratch, 2. Won by a touch.

OBSTACLE RACE.—Heat 1: H. Glover, 1; G. F. Sims, 2. Heat 2: G. Schlesinger, 1; A. Moberley, 2. Final: H. Glover, 1; A. Moberley, 2.

FULL CLOTHES RACE.—F. Edey, 1; B. C. Scott, 2.

POLO MATCH.—Shortly after the commencement, Ball, after some scuffle with one of his own side, shot a good goal. Graham Marshall passed to Styer, who sent in a hot shot, which Eccles saved. The ball travelled to the other end of the bath, Glover making a good dribble, which ended in him beating Dawson with a corner shot. Some fast play followed, Styer showing to great advantage, eventually scoring (2—1). Ball, after the throw-in, made a good rush, and passed to Pritchard, who returned it, and the first-named player, beating Styer, registered the third goal for the Present. From the throw-in, Graham Marshall, whose defence was magnificent to watch, passed to Styer; Ball spoilt well, but a penalty was awarded to the Past. York Moore passed to Styer, and the latter put in a warm shot, the score at half-time being 3—2 in favour of the Present.

In the second half, Moberley and Clark scored a goal each, whilst Styer registered two for his side. This latter player and Graham Marshall played magnificent polo, and the final result 5—4, speaks volumes, for the Present had a very strong combination out. Teams:—

PAST.—Dawson, Taylor, Reeve, Graham Marshall, Styer, York Moore, A. N. Other.

PRESENT.—Eccles, Ball, Rice, Clark, Glover, Moberley, Pritchard.

Cases of Renal Calculus.

CLINICAL LECTURE BY F. J. STEWARD, M.S.

GENTLEMEN,—I propose to illustrate some of the points connected with renal calculus, by describing several cases.

The first case was a woman, æt. 54, who was admitted into Lydia ward on March 16th this year. For four years she had had aching pain in the left side, especially on exertion. Three months ago she had a more severe attack of pain in the left loin, spreading down into the groin. Soon afterwards blood appeared in the urine. She had to go to bed, and the pain gradually ceased and the urine became free from blood. She stayed in bed a fortnight, but on getting up, pain, in a less severe form, returned, and continued, on and off, until admission. She appears to have passed blood on several other occasions. She came to out-patients three weeks before admission, and was seen by Dr. Fawcett; there were definite traces of blood in the urine at that time. On admission, the left kidney region was found to be slightly tender on deep palpation. There was no sign of tenderness over the right kidney, and neither kidney could be felt. The temperature was normal, and the urine free from blood, pus, and albumen. So far, the history points to some lesion in the left kidney. When there is pain in one loin, associated with attacks of hæmaturia, there is almost certain to be something the matter with the kidney on that side. What are the probable causes of these two symptoms? The most frequent is renal calculus. Tubercular disease of the kidney will, however, cause the same symptoms. Usually with stone there is more pain than hæmaturia, whereas tuberculous disease, as a rule, gives rise to more hæmaturia than pain. I have operated on about twelve cases of tubercular disease of the kidney, and in all of them the main symptom was hæmaturia. There are other causes of these two symptoms. Moveable kidney is one. Here, there is always pain, but only very rarely hæmaturia. If the kidney is very moveable, the structures in the pelvis making up the pedicle of the kidney may become kinked sometimes, causing great congestion of the kidney, associated with severe pain and the passage of blood. The next possibility to be considered is new growth, and there may be various forms in the kidney which will cause haæmaturia and more or less pain. For instance, malignant growths may cause hæmaturia to be the most pronounced symptom, with pain to some extent, though not so marked as in calculus. Sometimes quite a small innocent growth—papilloma or nævus—in the pelvis of the kidney will cause severe hæmaturia.

The amount of pain which this woman had was strongly suggestive of the presence of stone in the kidney, clearly not of moveable kidney, because we could not feel either kidney. She had not tuberculous kidney, because the kidney was not enlarged, and the urine was normal. Moreover, in most cases of tuberculosis of the kidney there is a rise of temperature, but in this case there was none. With regard to growth, you will remember the history had extended over four years. If malignant growth had lasted as long, and caused pain, the kidney would have been markedly enlarged, and one could not have missed it. The question still remained as to whether it might be one of those small innocent growths I have spoken of, such as papilloma in the kidney pelvis, or a nævus. With a view to finding out whether she had a stone, or one of these other comparatively rare forms of hæmaturia, it was necessary to carry out further investigation. There are two further aids which you can employ. You can examine the bladder by means of the cystoscope. As her urine was normal we did not do that. If there had been blood in her urine it would have been useful to find out which ureter the blood was coming from. Again, in cases of stone in the kidney, there is occasionally prolapse of the ureter or changes in the orifice, although these are comparatively rare. When you do see them, they give a very clear indication that the kidney is affected. From a stone in the pelvis being constantly engaged in the ureter, and the attempts made by the ureter to pass it down, a certain amount of prolapse may take place, so that the orifice appears swollen, and a projection may be seen coming from it. The other means of investigation is an X-ray examination, and naturally that was done. The result was a great surprise. You will remember that all her pain was in the left kidney region, and, apart from that, her only symptom was hæmaturia. The report says, "there is an opacity, apparently consisting of several small calculi, in the *right* renal region, opposite the second lumbar transverse process, and one inch external to it. Numerous opaque masses, due to fæces, especially on the left side, but no evidence of stone in the left kidney." The skiagram, you see, shows the stone very well.

Now this brings us to the question as to how much value X-ray examination is in cases of

renal calculus. In examining the value of evidence of this kind it is necessary to consider the question in two parts: first, the value of positive evidence, and secondly, the value of negative evidence. With regard to positive evidence, if a radiographer reports that he sees an opacity in the kidney which he considers to be a renal calculus, I think there is very little doubt about there being a stone in the kidney. So that positive X-ray evidence is almost absolute. I have operated on a considerable number of cases in which there has been positive evidence of renal calculus, and I have never found it to be wrong. But there are certain fallacies which must be borne in mind. There may be a localised tuberculous deposit in the kidney, which has undergone cure, with a deposit of calcium salts in the caseating material. Such a mass may cause an opacity which, in the X-ray photograph, is indistinguishable at times from renal calculus. The other mistake sometimes arises from calcareous glands in the abdomen. An old tuberculous gland in the mesentery, or in the meso-colon, becomes calcareous, and consequently opaque to the rays. And if that gland is in front of a kidney, it may cause a shadow which appears to be in the kidney substance. With the exception of these two possible fallacies, I think you may regard positive X-ray evidence as absolute. Next comes the question whether as much importance can be attached to negative evidence. It is certain that negative evidence is less reliable than positive. If the patient is examined carefully by a skilled radiographer, and he reports that he cannot see anything in the kidney, it does not necessarily follow that there is no stone present. Let us examine for a moment the fallacies in connection with negative evidence. The question of the composition of the stone comes in, for the degree of opacity to X-rays varies according to the composition. Oxalate of lime stone is the most opaque, and it stands out with marked distinctness. Next come phosphatic calculi, or calculi which have a marked phosphatic deposit on them. Less opaque stones are those of uric acid and urates. Very rarely cystine and xanthine calculi are found in the kidney. These are less opaque than phosphates, and more opaque than urates, so that it is possible for a patient to have a uric acid or urate stone without it being visible on X-ray examination. Sometimes, owing to the colon being full of fæces, it is impossible to distinguish a stone in the kidney, so it is most important to see that the patient has the large intestine thoroughly emptied before the X-ray examination is made. Another thing which makes the examination of the kidney much easier is to inflate the colon with air.

Again, if the kidney is full of pus, a stone may not be seen in an X-ray photograph. Lastly, it is important to remember that very stout subjects are more difficult to examine than thin persons. In a stout person even an oxalate of lime stone may not be detected by the X-rays.

To return to the first case, as I have said, a distinct shadow was seen in the right kidney, and nothing on the left side, which was the side on which the pain was felt. The question now arose as to how much importance was to be attached to the X-ray examination in this particular case. Now it has been definitely proved that all the pain due to stone on one side may be referred to the other side; and since X-ray examination has become so satisfactory, that fact has been demonstrated more and more frequently. This is the second case I have seen in which the symptoms were referred to the opposite side to that on which the calculus was present. Even before the days of X-rays this possibility was recognised, and it possibly accounts for some of the failures to find a stone by operation owing to the wrong kidney being explored. It was, of course, possible that this patient had stone in the left kidney as well as in the right, the former being the cause of the pain, and for some reason unrecognisable on X-ray examination. However, the skiagram shows the stone on the right side so clearly that it did not seem likely that if one were present on the left side it could have been missed. I therefore decided to abide by the skiagram and operate on the right side. This I did on March 24th, and explored the kidney through the loin. The stone could easily be felt, and on making an incision into the kidney, was readily freed from the kidney substance and delivered through the wound. The aperture in the kidney was then closed with catgut sutures, then the muscles, and finally the skin, and the patient was sent back to bed. I show you the stone. I do not know what its exact composition is, but it is rather interesting, because on the surface there is a crystalline deposit, probably of some calcium salt. The deeper part, which was so opaque to X-rays, is doubtless oxalate of lime. It is an irregular stone, and it was partly embedded in the cortex, and partly projected into the pelvis of the kidney. The patient did quite well, and I have recently heard from her doctor that she is still in good health. So the probabilities are that we were right, and that

the cause of her pain on the left side was a stone in the right kidney.

Before speaking of general symptoms, I will describe another case, that of a woman, æt. 36, who was in Lydia Ward five years ago. Her history is, that for eighteen months she had been having attacks of severe renal colic on the right side. Each attack was associated with violent pain, which commenced in the loin, and radiated through the groin to the thigh. The pain was extremely severe, and associated with great prostration, and often vomiting. The attacks of pain lasted for two or three hours, and then passed off, either gradually or suddenly, leaving a feeling of aching and soreness in the loin lasting several days. Most of the attacks were followed by hæmaturia, and on several occasions she passed small stones. It is clear that, on the occasions when she passed stones, the sudden relief of pain was due to the fact that the stone traversed the length of the ureter and was suddenly delivered into the bladder. That accounts for the suddenness with which the pain ceases in some of the most severe attacks of renal colic. As a rule, the pain passes off more gradually, because it is due to a stone in the pelvis becoming engaged in the orifice of the ureter, and finally falling back into the pelvis. There was no doubt about the diagnosis in this case, because she had typical renal colic, hæmaturia associated with it, and she passed stones, some of which she brought to the hospital to show us. I mention this case because it illustrates a special point in connection with renal calculus which you do not often meet with. It was that, on examining her kidney, it was found not only enlarged and tender, but, in addition, one could feel that there were multiple stones in the kidney, because by palpation between the hand in front and one behind the loin, one could feel them grating against each other, and causing a sensation similar to the feel of a chicken's crop after a meal. Here again the X-ray examination was positive, the report stating that a large number of stones were present. I operated upon her in the usual way, and found, in the lower part of the kidney, a sac as big as a hen's egg, which contained a large number of calculi. There were altogether 108 calculi, of different shapes and sizes, as you see. There was one larger than the others, and it was a typical oxalate of lime calculus, with little knobs on it, and of a dark brown colour, owing to altered blood.

A third case is that of a woman, æt. 25, who was in Lydia ward recently. She was admitted on April 2nd. Her history is somewhat vague, but I have picked out the essential points. She seems to have suffered a varying degree of pain in the back, not referred especially to either side, and it had existed for three or four years. That is a rather important point, and it is one reason why I have made use of this case this afternoon. This failure to refer the pain to either side is not infrequent in renal calculus. I remember very well a man who came to my out-patients some years ago, and who had been treated by various doctors for five years for pain in the back. He had used all sorts of liniments, plasters, and blisters. The pain was referred to the top of the sacrum, and it persisted whatever he did. I had an X-ray examination made, and it showed a stone situated in the left kidney. This shows how important it is, in these cases of intractable pain in the back, to have an X-ray examination made, and to carefully examine the urine. On several occasions this woman's water had been thick, but she does not seem to have passed blood until quite recently. A few days before admission she developed profuse hæmaturia, and it was for this she was admitted into the ward. There was frequent micturition, and the act caused her pain. This is not unusual in stone in the kidney; and is due to reflex effects set up by the stone. She had also pain on the right side, but there was no tenderness. An X-ray examination was made on April 9th, and the report is: "Radiogram shows a fair-sized calculus in the right kidney, and it is opposite the upper border of the third lumbar vertebra, and one inch external to it. It moves with the kidney on respiration, and it is apparently an oxalate in the pelvis of the kidney at the exit into the ureter. There is no evidence of stone in the ureters or bladder." I operated on April 14th and removed the stone, which was very slightly embedded in the cortex, but projected into the pelvis of the kidney, as described in the X-ray report.

I have described three cases of renal calculus, and you will note that in each of them the essential features were pain and hæmaturia.

The character of the pain which patients complain of with renal calculus varies immensely. It may be simply a dull ache, or an aching back, or it may be pain of the most violent and paroxysmal nature, in fact, the severe pain which is described as renal colic. Between those extremes there may be any possible degree. The character of the pain is determined, to a certain extent, by the position and form of the calculus. If it is situated in the cortex of the

kidney and is immoveably fixed so that it cannot irritate the mucous membrane of the pelvis, or become engaged in the orifice of the ureter, the pain is usually more of a dull ache, which is generally increased somewhat after exercise, because the kidney gets squeezed by the movements of the surrounding muscles, and that leads to congestion, and hence to increased pain. Occasionally pain is the only symptom of renal calculus. It was so in the case I have described to you, which came to my Out-patients' with only pain in the back; and it was so in a very interesting case which I had in Dr. Pitt's ward, that of a woman who had been taken in on account of pain on the right side, in the situation of the right kidney. She was kept in bed and dieted carefully, but nothing made any difference to her pain. Her urine never contained any abnormal constituent, and her kidney region, when examined in the Radiograph Department, showed no abnormality. However, this ache was so constant, and it became so clear that there was something abnormal in the kidney, that I was asked to operate. I found a tiny stone in the kidney cortex. It was flat, $\frac{1}{8}$in. wide, and about the size of my little finger nail.

Supposing the stone is in the pelvis of the kidney and is moveable, if it is small it is certain to get into the ureter and give rise to a severe attack of renal colic, just as in the second case I have described, where the stones passed down from the kidney into the bladder, and were evacuated with the urine. On the other hand, a stone which is loose in the pelvis of the kidney will cause pain in other ways. Owing to its movements, it causes pyelitis, and the congestion of the mucous membrane causes aching pain. From time to time the stone will be caught in the orifice of the ureter, and there will be severe pain radiating from the loin along the ureter into the groin, or into the testicle (or labium of the female). It may be so severe as to cause prostration, great perspiration, and even severe vomiting. It is generally relieved when the stone either falls back into the pelvis of the kidney or escapes after having made the entire passage of the ureter. In such cases the testicle may be not only tender, but swollen; I have seen a case of the kind in which there was considerable swelling of the testicle. As the stone increases in size it is not so easily engaged in the orifice of the ureter, the attacks of pain become less frequent and less severe, and finally ceasing, leave only a dull aching pain, caused by the pyelitis, which is sure to be present.

With regard to hæmaturia, that varies immensely in degree. If there are attacks of renal colic, there is nearly always hæmaturia subsequently, lasting a few hours or a few days. Where the stone is embedded in the cortex of the kidney, the hæmaturia may be quite slight, and it may only be provoked by exercise, or by a railway journey. Sometimes blood is not recognised when it is present, and it is important in these cases to centrifugalise the urine and examine the deposit microscopically. I have had several cases in which that has revealed red blood corpuscles, and the patient had no idea that blood had been passed. In rare cases of renal calculus, hæmaturia is excessively severe, presumably the result of ulceration of some vessel in the pelvis of the kidney. The following case illustrates this condition very well.

A girl was admitted into Lydia Ward on December 21st last. Her notes are these:— Last July her foster-mother noticed her urine was pink, but, thinking it was possibly the onset of menstruation, she took no further notice. It, however, got worse, and for the eight weeks preceding admission the urine was claret-coloured. The patient began to get pale two months before admission, but she has had no pain or inconvenience during the whole period, and until the last week she has been to school. After admission, she continued to pass large amounts of blood in her urine, and in fact it was always claret-coloured. We kept her in bed, but this made no difference. She was distinctly anæmic from the amount of blood she was losing, but she had neither pain nor tenderness. The question arose as to where this blood was coming from, and I suspected a growth of the bladder. So, early in January I examined her with the cystoscope. There was no growth in the bladder, but after washing out the bladder several times with hot water, to get it clear of blood, we were able to see the blood spurting at intervals from the orifice of the left ureter. No blood was seen to come from the right ureter. X-ray examination revealed a stone in the kidney. I therefore explored her kidney, and found a large hydronephrosis, and a large stone impacted firmly in the orifice of the ureter. There was clearly ulceration of the pelvis, and presumably of some vessel from which bleeding was going on. Therefore, as there was marked hydronephrosis and very little renal secreting substance left, I removed the kidney, and she did well.

In addition to pain and hæmaturia, there is usually tenderness on palpation and deep pressure.

In many cases also there is more or less enlargement of the kidney, which may therefore be palpable. Further symptoms are those of the various conditions which may result from the presence of a stone in a kidney, such as pyelitis, hydronephrosis, pyonephrosis, or perinephric abscess.

I had hoped to go into the question of treatment, but there is not time. You will, however, have gathered certain facts about treatment from what I have already said.

Change of Address.

Mr. Harold J. Dear, from Ellerslie, Sydenham, S.E., to 18, The Hawthorns, Church End, Finchley, N.

Surgeon R. W. B. Hall, from H.M. S. *Gladiator*, to Royal Dockyard, Gibraltar.

Mr. I. Levy, L.D.S., from Guy's Hospital, to Park Lodge, 150, Highbury New Park, N.

Mr. W. E. Lowe, L.D.S., from 104, Willis Street, Wellington, New Zealand, to 314, Esmeralda, Buenos Ayres, Argentine.

Mr. F. Newland-Pedley, F.R.C.S., from 32, Devonshire Place, W., to 22, Willow Road, Hampstead, N.W. (Telephone, P.O. Hampstead 3046.)

Dr. W. H. Robinson, from Croft House, Moorgate, Rotherham, to Scarborough Hospital and Dispensary.

Mr. J. F. Ryder, L.D.S., from Hetherset, The Rye, Peckham, S.E., to Montague House, 194, The Rye, East Dulwich, S.E.

Dr. Gerald A. Ticehurst, from 10, Grand Parade, St. Leonards-on-Sea, to 54, London Road, St. Leonards-on-Sea.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

BOOKS RECEIVED.—Sir James Sawyer's Physical Signs of Disease of the Thorax and Abdomen; Proceedings of the Royal Society of Medicine, Part 7; Hutchison and Rainy's Clinical Methods, new edition; Whitelegge and Newman's Hygiene and Public Health, new edition: Leduc's Electric Ions; Tibble's Theory of Ions; Fisher's The Heart and Sudden Death; Coleman's Extraction of Teeth; Catalogue of Lewis's Medical Library; Brook's Aids to Tropical Medicine; Jessop's Ophthalmic Medicine and Surgery; Schmidt's Jahrbücher for June, 1908; Brain, May, 1908; Virchow's Archiv., June, 1908; Journal of Pathology and Bacteriology; Archives Générales de Médecine, May, 1908; Journal of Obstetrics and Gynæcology, June, 1908.

Some Essentials in Dental Practice.

CLINICAL LECTURE BY MR. W. A. MAGGS.

GENTLEMEN,—In this lecture I intend to deal with a few practical points of every day occurrence, trivial perhaps in themselves, but yet of great importance to our patients and to ourselves; or, metaphorically speaking, to dot the i's and cross the t's of daily practice, rather than to cover new ground.

Dentists, like other persons, require to recognise the relative importance of, and to distinguish between, essentials and non-essentials.

First, patients should be spared as much pain as possible. We are, perhaps, liable to forget how extremely sensitive some individuals are, and constant familiarity with operations, which are always more or less painful and sometimes tedious, may lead to relaxation of our efforts for the relief of pain.

a. Take, for example, the use of a dental probe; it is often needlessly and thoughtlessly driven into the pulp of a tooth or into the gum, thereby causing much unnecessary suffering. No instrument, in my opinion, is more misused or abused. Its use should be limited to searching for small carious cavities, defective margins of fillings, and partly erupted teeth.

b Sensitive dentine can be removed with a minimum amount of pain, provided *sharp* burs and excavators are used.

The hot-air syringe and a local anodyne, usually called an obtundent, are often helpful to the patient during the excavation of sensitive dentine, but if these and similar means fail, it is bad practice to continue the excavation, and a filling of oxysulphate of zinc should be inserted for a few days.

c. A high speed of running the drill by the foot or electric dental engine causes great heat to be evolved with consequent pain, and this should be avoided.

d. When the pulp of a tooth is exposed the excavation should be discontinued, and either cocaine hydrochloride under pressure applied and the nerve removed at that sitting, or arsenious acid with morphia used, a temporary filling inserted, and the pulp extirpated at a subsequent visit.

e. Any form of mallet used for condensing gold fillings may cause unnecessary discomfort, owing to the blow being too heavy.

f. Nitrous oxide gas and local anæsthetics give such excellent and safe results for extractions, that most dental operations can now be performed without much pain.

Secondly, oral surgery demands methods of cleanliness as thorough and exacting as those adopted by operative surgeons.

The "toilette of the mouth" should be as rigidly carried out as the "toilette of the abdomen," because micro-organisms of the mouth may be conveyed from

patient to patient by the hands or the instruments of the dental surgeon, and every precaution should be taken against such mishaps.

It is never justifiable to go direct from one patient to another without a thorough cleansing of the hands.

The nails of the operator should be kept short, well-trimmed, and scrupulously clean, and the hands thoroughly scrubbed for several minutes with a nail brush and plenty of soap and running water.

Some antiseptic should be added to the water; it is immaterial what kind is employed provided it be diligently used, but perchloride of mercury, lysol, or lysoform may be mentioned as being amongst the best.

All extraction forceps, excavators, scalers, burs, and clamps, should be mechanically cleasned after use, and finally boiled for twenty minutes; in short, each patient should be regarded as a possible medium of bacterial poison which may be communicated to others if the greatest care is not exercised.

Nerve instruments and matrices should be cleansed by means of a brush, and sterilized by immersion for fifteen minutes in carbolic acid, 1 in 20.

An unused hypodermic needle, being inexpensive, should be employed for each patient; and mouth mirrors, saliva tubes, and probes, kept constantly in an antiseptic solution.

The addition of some antiseptic to the warm water given to the patient for rinsing out the mouth is always advisable, and becomes necessary after the extraction of a tooth, or the operation of scaling, owing to the jaw and gums having been wounded or abraded.

Surgical cleanliness is of the utmost importance, and all soiled linen should therefore be immediately removed from the operation room. A plentiful supply of hot and cold water and a spittoon supplied with running water are essential requisites for every operation room.

Thirdly, it is very desirable that all teeth and roots be removed that cannot be rendered aseptic. Pus in any part of the human body is incompatible with health, and there is no more common cause of ill-health than that due to suppuration around the teeth. The suppuration may be limited to the pulp, or the lymphatic glands in the neighbourhood may be secondarily involved, or it may affect the alveolo-dental periosteum, but, in any case, the consequences may be serious and widespread if the condition be not combated by local treatment.

The constant swallowing and absorption of small quantities of pus bring about toxæmia and a lowered state of vitality, which are shown by pallor, debility, neuralgia, and various forms of chronic gastritis and enteritis, often called "anæmia" or "rheumatism" by the patient.

The auto-intoxication due to chronic suppurative periodontitis may give rise, in extreme cases, to the grave condition known as "pernicious anæmia." In an address before the Odontological Society of Great Britain, October, 1901, I stated that: "A septic condition of the mouth, tolerated in ordinary health, may become a source of great danger to the patient during an acute specific illness, such as typhoid fever, ulcerative endocarditis, or pneumonia, and may be an important factor in the issue of the case. It has been observed that severe abdominal operations, successfully performed, in which the local results are satisfactory, are sometimes followed by indications of blood-poisoning, parotitis, and death. The inflammation and rapid sloughing of the parotid gland are apparently not due to the effects of the operation, but to the condition of the mouth and teeth. It follows, therefore, that the mouth of the patient should be clean, as well as that of the surgeon and nurse, in order to ensure the best results in operative surgery. Of course, many operations are urgently called for, and any delay in putting the patient's teeth in order is out of the question." It is the duty of dental surgeons to impress upon their patients the evils that may arise from retention of septic teeth. Radical treatment by extraction should be undertaken prior to any other dental treatment except scaling.

Fourthly, the rubber-dam is invaluable in dental practice. From many years' constant use of it—perhaps in 90 per cent. of the cases of permanent fillings—it is my conviction that the work can be done with less pain, more thoroughly and more quickly than without it. Excavation of the cavity with the rubber-dam applied can be performed with less pain to the patient, because dry dentine is less sensitive than moist, and the hot-air syringe and obtundents act more easily; moreover, the work can be done more thoroughly, because the cavity being isolated the cervical edge and the margins can be dealt with more deliberately and without fear of the cavity being flooded with saliva than when it is not employed.

Furthermore, the sterilisation of the dentine can be more efficiently carried out, and the filling inserted more quickly when the rubber-dam is used, because no time is lost in the constant rinsing out of the cavity by the dentist, or of the mouth by the patient.

There seems to be no valid reason for neglecting the use of the rubber-dam excepting in the case of the very young or very old, or when it is impossible of application owing to the cavity extending below the gum margin, or when its employment is contra-indicated owing to the general condition of the patient, *e.g.*, advanced cardiac or other organic disease. It is sometimes urged that patients, especially those suffering from enlarged tonsils or adenoids, object to its use, but that is not my experience with the "Fernald" form of retractor used at Guy's, in fact it is generally preferred to a serviette unless there is a great loss of self-control on the part of the patient, or in young children for temporary teeth, where it is not needed.

Again, it is said that it is unnecessary in the treatment of upper teeth unless a gold filling is to be inserted, but in my opinion the rubber-dam is always advantageous to the patient and operator.

It is also asserted by some that time is lost in the adjustment of the rubber, but its application becomes,

with practice, a simple matter, usually occupying only a few minutes.

Fifthly, a deliberate opinion about a case is essential. There is no reason for forming a hurried diagnosis, and it is better to take notes if it be obscure, or models of the mouth, if necessary, and to give an opinion later. Having come to a conclusion as to diagnosis and treatment, make your decision known to the patient, and stand or fall by it.

Nothing shakes the confidence of a patient more than indecision, and an undecided man is a weak man in any position of life. When you again see a patient after an interval of time, start *de novo* with a consideration of the case from the patient's point of view, and see how far your opinion coincides with your previous judgment, and amend the latter if circumstances demand it.

Do not mistake my meaning: I do not want you to form hasty and perhaps immature judgments, and to adhere to them dogmatically, but to have the courage of your convictions.

Sixthly, carious cavities should be opened up from the crowns of the teeth, and root canals of devitalised teeth filled to their apices.

Beginners excavate interstitial cavities in the cheek teeth by means of variously-shaped "spoon" excavators, instead of cutting down the enamel from the crown. By removing overhanging enamel walls, which would break away if left, such cavities can be prepared in a better manner, the operator gaining a clear view of the floor and margins of cavities, and secondary caries at the cervical margins is largely prevented.

It is abundantly evident in daily practice that the successful filling, crowning, or bridging of devitalised teeth depends upon their root canals being plugged to their apices with an antiseptic material. Sooner or later, bacteria will develop in the unfilled apex of a root canal, and conservative treatment will fail owing to the onset of periostitis, neuralgia, or alveolar abscess. If the roots are imperfectly filled the finest work done later is doomed to failure. At the same time, it is admitted, on all sides, that it is extremely difficult to fill efficiently the root canals of some molars, because of their irregular shapes and small calibre.

It is a good object-lesson to split open and examine all devitalised teeth after extraction, in order to ascertain how far you and others have failed to reach the apices of the canals.

In concluding this lecture I desire to lay down the following axioms:—

Dentists should be considerate to patients.

There is no excuse for dirty hands or instruments.

Septic teeth are a source of danger in the mouth.

The employment of the rubber-dam is a benefit alike to patient and operator.

Dentists should be decisive in their opinions.

The success of the treatment of devitalised teeth depends upon the roots being well plugged to their apices with an antiseptic material.

Reviews, etc.

The price of books submitted for review should in every case be stated.

The Pocket Osteology. By Phillip Turner, B.Sc., M.B., M.S. (Lond.), F.R.C.S. (Baillière, Tindall & Cox.) 3s. net.

We congratulate Mr. Turner on his excellent little manual. To have expressed in such a short space so difficult a subject as osteology in such a lucid manner is a most creditable performance. Though, perforce, diagrams are excluded, yet this little book will come as a boon to those men who have already done the drudgery of learning the bone for the first time and are anxious to brush up their knowledge. As a companion to the Pocket Anatomy it will be much in demand. The subject-matter, of course, is that of present-day anatomists, whilst the sections which, we venture to think, will be most popular are those devoted to ossification. There is no doubt that a small compact volume on this subject was wanted, and we heartily recommend Mr. Turner's book to all men desirous of possessing such a manual.

Handbook of Medicine and Therapeutics. By Dr. Alexander Wheeler and Dr. W. R. Jack. (Messrs. E. and F. Livingstone.) 8s. net.

We have received a copy of the third edition of this work. An attempt is made, within the compass of five hundred pages, to cover the whole field of medicine. To the student preparing for examination its modest proportions will perhaps seem attractive. To have presented to him the pathology, symptomatology and treatment of appendicitis in two and a half pages of small size, may very well give him a gratifying sense of progress. That he is likely to benefit in any other way is, we think, extremely doubtful. To claim, as is done in the preface, that such an article can possibly "form a useful complement to the bedside study of disease," is absurd. In so small a book to attempt completeness is certainly to court failure. It would surely have been better to have taken an elementary knowledge of the subject for granted, and to have occupied some space in enforcing distinctions, or in pointing out associations between different conditions of disease. Every student, as an aid to memory, must make some sort of an abstract of the descriptions of disease which he finds in the text-books of larger size. The task of compiling such an abstract in itself is likely to fix in his memory the points which he must have in mind. But to present him with such an abstract ready made, is not likely to serve any useful purpose. The book is too small to serve as a work of reference; it is written in too abrupt and jerky a style for continuous reading. Although for these reasons we doubt the utility of the book, no fault can be found with the way in which the work of abstraction has been done. The lists of symptoms and physical signs are accurate and complete. The weakest point lies in the sections dealing with

treatment, a subject on which it is nearly always impossible to be dogmatic. Important points are throughout emphasized by the use of italics.

Proceedings of the Royal Society of Medicine (May). Vol. i., No. 7. (Messrs. Longmans, Green & Co.) 7s. 6d.

In the clinical section is a paper by Drs. Forbes and Langmead on lymphocythæmia in early life. The paper is one which can profitably be read by all advanced men, giving as it does such excellent descriptions of many cases, and being rendered very easy to read by the introduction of two marvellously complete tables—one giving the clinical features, the second the post-mortem appearances. It is interesting to note that the authors are opposed to a microbic origin.

Mr. Symonds, we notice, showed that case of complete excision of the larynx with Gluck's appliance for improving the speech, which many of us have seen.

Mr. Sampson Handley showed two cases of lymphangioplasty for the brawny arm of breast cancer—the method was described in the *Lancet* of March 14th, 1908—and the results are most striking.

To the electro-therapeutic section Dr. Reginald Morton contributes a valuable paper on the electrical treatment of atonic conditions of the digestive system.

In the obstetrical and gynæcological sections we find a most interesting case of intra-uterine death in six consecutive pregnancies, reported by Drs. Holland and Williamson. Special investigation showed that the spirochætes were present in the liver and spleen of the fœtus. This is interesting in that there was an absolute negative history of infection in the mother, and not a single clinical manifestation. After a course of mercury and iodide of potassium, the patient gave birth to live twins. These died some weeks later of immaturity—some hydramnios and the twin pregnancy caused an error in diagnosis, and induction was practised too early. Investigation of liver and spleen, however, in both dead children failed to reveal the presence of the spirochætes. Levaditi's method of staining the spirochætæ is detailed at length.

In the therapeutical and pharmacological section, Dr. Leonard Guthrie's paper on rheumatism and chorea in childhood should be read by all senior men. The printing and illustrations are well up to the usual high standard of this production.

Electrical Treatment. By Wilfred Harris, M.D. (Cantab.), F.R.C.P. Lond. (Messrs. Cassell & Co.) 7s. 6d.

This book gives a most comprehensive account of the various forms of electrical treatment as practised at the present time, and we are pleased to note that special attention is devoted to what may be accomplished in general practice by faradic and galvanic currents. The author is to be congratulated on his clearness. The chapter on methods and apparatus reads very lucidly, but diagrams would have assisted. The various diseases and conditions in which faradic and galvanic currents are used, are dealt with fully, the method being described in each case. A chapter on electrolysis and the treatment of nævi, aneurysm, fibroids and superfluous hairs and moles (why superfluous? all moles are that, surely), will be found of the greatest use. The sinusoidal current receives due attention, likewise electric light baths and X-rays. The practitioner will find everything which is necessary for him to know in the application of electro-therapeutics in his practice, whilst if he is in need of descriptions of more elaborate work, he will find that also. The practical value of this book is immense, and we know no better.

Song: "Time Was."

Composed by John Tanner, M.D., F.L.S., for the Guy's Hospital Biennial Festival, July 8th, 1908.

Time was—yes, fifty years ago,
Not wrinkled then, with hair like snow,
We worked up bones, and good work done,
Put books away and sought but fun.

Time was—when for exams. we read,
Crammed all day long, and knew not bed;
When passed, what pranks we played at night,
Returning home as day dawned bright.

Time was—dear chums! we got run in,
Paid fines for buoyancy—not sin;
But now what change has o'er us come,
Grown old, to find no place like home.

Time's up—our home we'll ne'er forget,
Although 'tis sad to part, but yet
We'll hope to meet again, drink wine,
Join hands, and sing, "For Auld Lang Syne."

CHORUS:

"For Auld Lang Syne," etc. (1st verse).

Papers by Guy's Men.

A Case of Appendix Rupturing during an Operation, and an Analysis of the Meaning of the Symptoms. By F. R. B. Bisshopp, M.D. Cantab., M.R.C.P. Lond., and John D. Malcolm F.R.C.S. Edin. (Illustrated).—*Lancet*, 6th June, 1908.

Three Years' Experience of Butlin's Operation for Cancer of the Tongue. By F. T. Paul, Ch.M., F.R.C.S. Eng.—*British Medical Journal*, 6th June, 1908.

Temperance Reform.

A Suggestion.

Much attention has been attracted, of late, by the address delivered by Mr. McAdam Eccles on the occasion of the Lees and Rapier Lecture, delivered at Oxford some short time ago before a distinguished assembly. He chose as his subject, "The Relation of Alcohol to Physical Degeneration and National Efficiency," and his manner of dealing with it appealed to an audience consisting, not only of rabid temperance reformers, but also comprising a large section of moderates.

He pointed out that alcohol, as an agent in the deterioration, physical and otherwise, of the nation, played no small part; and his suggestions for dealing with what must now be regarded as a great national question were interesting in the extreme. He contended that an elementary course of hygiene taught at schools would do much to educate the rising generation to understand the all-importance of questions of cleanliness and personal care.

Let me extend this suggestion. Say, for example, that in the lower standards the children be taught by methods—Kindergarten or otherwise—that cleanliness is as great as godliness, that the necessity of personal care is a factor in maintaining the standard of national efficiency—this by means of stories with a striking moral, or even by promoting a wider interest by presenting prizes, etc.: in the highest standard the children will be in a position to have taught to them the elements of the sciences, and they may then be inculcated with the idea that in the ætiology of all diseases, dirt plays an important rôle. Side by side with this education will grow the gradual understanding of what is bad for the organism.

So will come the appreciation that excess spells harm, and so, also, an excuse—I am loathe to put it this way—to keep away from those excesses will become apparent. Naturally, this rising generation will be a critical one: it will want proofs.

In the case of tuberculosis, incalculable good has been done by Congresses, Commissions, and Exhibitions; that is, by the amassing and subsequent dissemination of known facts for its prevention. Even though these results may only be apparent to the masses by the notices of "Please don't spit," displayed in public vehicles and public places, nevertheless, I have no hesitation in saying that the objectionable habit of promiscuous expectoration has been considerably curtailed; behind it all being the idea that, in some way, spitting is dangerous—to others. Here, then, is an example of what scientific research and properly organized methods of prophylaxis have done.

Take, then, the case of alcohol. Let there be commissions, exhibitions, etc.; let the discovered facts as to the detrimental action of this compound, *taken in excess*, be made known. Of course, this will not appeal to the present habitués of public-houses and gin-palaces; they are past reform, either by the present measure before the country, or indeed any other method. No, this suggestion is for our "critical" generation which is to grow up with a better capacity for understanding.

Still, another suggestion which Mr. Eccles made, and which time and again must have appealed to many—namely, increased facilities for the better enjoyment of the working-classes. The improved education—hygienic—of our school children will give, to the one or two rooms, which the denizens of our poorer parts call "Home," a greater significance. Material comforts will follow, and naturally more cleanly habits. But some recreations will be necessary to replace what, at the present time, is the one and only centre of enjoyment available for the working classes—to wit, the public-house. Or, to be more lucid, these present-day public-houses will have to offer greater attractions to their clientèle than the homely pot of half-and-half served under conditions which are anything but ideal from an hygienic point of view; remember, I still speak of our "critical" generation. These places will have to take the form of a winter garden, or something similar, where, if not music—and I am certain that there is a latent love of the same lurking in an English working-man's heart—some other form of recreation is given.

This, then, is the shape which Temperance Reform might well take; a progressive education of the generation now growing up, so that it may see for itself the harm which follows excess, and choose a midway course which will not abolish, but merely change, the present-day system, and bring it into line with what then will be necessary.

A CORRESPONDENT.

Sport.

United Hospitals Athletic Meeting

This meeting was held at Stamford Bridge on Wednesday, June 17th, 1908, in very dismal weather and before few spectators. We must congratulate Tucker and R. M. King on their winning the Hammer and Three Miles respectively. In the Three Miles Adams, as second string, ran exceedingly well and did much towards making King's journey easier for him. We also took seconds in the Hurdles by Renton, who got a poor start, Quarter-mile by Mather, who ran well, and Hammer by R. Rankine. We must say we are very disappointed not to have the shield resting in our smoking-room, but we little expected to have to compete against such a team as Bart.'s put in the field, which contained T. H. Just, England's first string in the Half-Mile at the Stadium, and T. Abrahams, the Cambridge sprinter. H. N. Eccles ran a splendid race in the Half-Mile, but had his usual bad luck in this race in having a crack man against him. The Tug of War fell to our team, and much credit is due to Mr. R. G. Oram for the trouble he has taken in coaching our combination.

The London University Sports.

On Saturday, June 20th, 1908, the Third Annual Meeting of the London University Athletic Union was held at Herne Hill. The conditions were perfect, except for the fact that the track, decidedly on the loose side, was therefore not conducive to fast time. Guy's were excellently represented, and we were pleased to see Mr. A. R. Thompson amongst the judges doing yeoman service.

In the HIGH JUMP our two candidates did exceedingly well, S. N. Browning winning the event with a jump of 5ft. 5¼in., while N. Reader tied with Whitehead Reid (of Bart.'s) with a jump of 5ft. 4½in. for second place.

In the HURDLES Renton, after beating Browning in a heat, won the final from Rice (London) in the fair time of 17⅕ secs.

THROWING THE HAMMER resulted in a first and second for our men, Tucker throwing it 99ft. 6in., and Rankine was second to him with a throw of 90ft. 6in.

The THREE MILES was, perhaps, the surprise of the afternoon for Guy's; Farr after running a well-judged race, won easily by fifty yards in 17 min. 34⅘ secs.

The RELAY RACE also fell to our quartet. N. Eccles was first to start, and although he was beaten into third place, W. W. Cook ran excellently and made up a lot of lost ground, and Renton, who was the next to start, took the lead by eight yards, which Mather, running last, maintained to the winning post.

The TUG OF WAR was just a walk over for our team, who were well trained, and certainly the only team who knew how to pull. In the first round we met and defeated in two pulls the King's College team, and the Central Technical College having beaten University College, we met them in the final. Here, again, our men beat them for weight, strength, and science, and won the event.

The team was:—R. G. Oram, G. Tucker, J. Pryce-Davies, H. Steinach, A. H. Crook, A. B. Danby, W. E. Williams, J. Watkin.

Football Clubs.

The Annual General Meeting was held on Thursday, June 18th, Dr. Frederick Taylor in the chair. After the Rugby and Association Club Secretaries had read their reports for last season, the following officers were elected to act for Season 1908-9. Dr. Frederick Taylor was re-elected President.

RUGBY.—Capt.: L. B. Stringer; Hon. Sec.: A. H. Crook; Capt. 2nd XV.: E. L. Elliott; Capt. 3rd XV.: W. P. Vicary; Committee; H. Hoby, J. G. Saner, H. Lee, G. R. Hind, J. P. Jones.

ASSOCIATION.—Capt.: C. A. Wood; Hon. Sec.: C. Witts; Capt. 2nd XI.: D. A. Mitchell: Capt. 3rd XI.: W. Matthews; Committee: P. Humm, A. H. Birks, R. M. King, C. H. Mills, H. R. Bastard.

Cricket.

GUY'S v. LONDON COUNTY.

Played at the Crystal Palace on June 11th, and ended in a draw.

GUY'S.

M. M. Munden, b Carter	41
C. H. Medlock, c Carter, b Cameron	15
R. Montgomery, b Cameron	44
P. C. Charlton, c Kenward, b Kanga	80
R. G. Chase, c Beaton, b Cameron	36
W. T. Clarke, c and b Cameron	31
N. E. Farr, c Montezuma, b Weir	16
J. H. Clapperton, c Cameron, b Kanga	17
F. C. Hunôt, c Kenward, b Cameron	2
F. Kahlenberg, not out	1
F. Tooth, not out	0
Extras	12
Total for 9 wickets	295

LONDON COUNTY.

R. Kenward, c Clarke, b Charlton	4
A. E. Beaton, c sub, b Chase	44
H. D. Kanga, b Tooth	47
W. A. Ingram, not out	43
J. J. Cameron, c Montgomery, b Chase	15
A. H. Wadia, c sub, b Kahlenberg	0
W. E. Warner, not out	8
Extras	1
Total for 5 wickets	162

L. De Montezuma, H. K. Whiting, E. Weir, —. Carter did not bat.

PAST v. PRESENT.

Played at Honor Oak Park, the Present winning easily.

PRESENT.

M. M. Munden, b Young	44
C. H. Medlock, c sub., b Edey	34
H. Lee, run out	89
R. Montgomery, b Edey	19
A. H. Birks, c Rook, b Edey	40
F. D. Saner, b Bookless	8
N. E. Farr, b Morres	34
W. T. Clarke, b Bookless	2
J. H. Clapperton, st Gibson, b Bookless	4
F. Kahlenberg, not out	7
Extras	23
Total for 9 wickets	304

F. Tooth, did not bat.

PAST.

A. M. Tolhurst, b Kahlenberg	0
J. S. Bookless, b Kahlenberg	13
R. S. Poyser, b Clapperton	29
H. G. Gibson, b Kahlenberg	7
F. Morres, c Montgomery, b Tooth	33
C. H. Fagge, b Clapperton	10
F. C. Hunôt, c Montgomery, b Clapperton	10
A. C. Rook, c Montgomery, b Kahlenberg	30
T. H. Edey, c Clarke, b Birks	14
H. R. Mullins, st Montgomery, b Kahlenberg	0
J. F. Young, not out	46
Extras	11
Total	203

CUP TIE.—GUY'S v. KING'S.

Played at Honor Oak Park on June 17th, and ended in a win for Guy's by 183. Charlton and Medlock each batted well, Charlton also capturing 5 wickets for 30 runs.

GUY'S.

M. M. Munden, c Addison, b Gillett	9
C. H. Medlock, c Hamilton, b Gibson	64
H. Lee, c Kanga, b Simmons	38
A. H. Birks, b Gillett	46
P. C. Charlton, not out	83
R. Montgomery, b Kanga	40
R. G. Chase, not out	20
Extras	11
Total (for 5 wickets)	311

Innings declared closed.

F. D. Saner, J. H. Clapperton, F. Kahlenberg, and F. Tooth did not bat.

KING'S.

F. Simpson, b Charlton	12
W. T. Briscoe, st Montgomery, b Charlton	32
H. D. Kanga, b Chase	42
A. S. Gillett, c and b Kahlenberg	8
H. E. Gibson, c Montgomery, b Charlton	13
H. L. Addison, b Chase	10
B. Hughes, b Charlton	1
J. MacQueen, b Charlton	5
H. Simmon, b Kahlenberg	1
D. Hamilton, not out	0
E. C. MacDonald, b Kahlenberg	0
Extras	14
Total	138

GUY'S v. BICKLEY & BROMLEY.

Played at Bromley on June 19th, and ended in a win for the Hospital. Scores:—

BROMLEY.

L. A. Shuter, c Charlton, b Kahlenberg	6
C. H. Hunter, b Charlton	5
A. Mark, c & b Charlton	12
C. L. Gregory, b Tooth	22
A. C. Tweedy, c & b Charlton	14
E. A. Willet, c Kahlenberg, b Charlton	19
J. W. Willet, c Charlton, b Kahlenberg	9
G. Davis, b Clapperton	1
E. P. Nicholls, c & b Charlton	2
F. C. Lamb, c Clapperton, b Charlton	13
H. Smith, not out	4
Extras	8
Total	115

GUY'S.

M. M. Munden, b Gregory	82
C. H. Medlock, c & b E. A. Willet	29
R. Montgomery, c Hunter, b Nickolls	17
A. N. Other, b Gregory	13
H. L. Duke, st Hunter, b Nickolls	0
P. C. Charlton, b E. A. Willet	15
W. C. Miller, not out	27
J. H. Clapperton, c E. A. Willet, b Nickolls	2
F. Kahlenberg, st Hunter, b Tweedy	15
S. Spill, b Tweedy	5
F. Tooth, b Tweedy	29
Extras	16
Total	250

GUY'S v. LESSNESS PARK.

Played at Honor Oak Park on Saturday, June 20th, and ended in a win for the Hospital.

GUY'S.

M. M. Munden, c sub, b Smith	0
C. H. Medlock, c Street, b Smith	5
H. Lee, b Upton	4
R. Montgomery, b Smith	2
F. D. Saner, c Upton, b Street	17
W. T. Clarke, not out	90
W. C. Miller, c Upton, b Street	16
J. F. Young, b Upton	19
P. S. Humm, c sub, b Smith	0
F. Kahlenberg, c sub, b Upton	0
F. Tooth, c Knight, b Street	55
Extras	17
Total	225

LESSNESS PARK.

E. Upton, c Medlock, b Kahlenberg	51
G. A. Rutter, b Kahlenberg	0
G. C. Griffiths, b Tooth	7
E. R. Jones, b Tooth	5
Street, b Kahlenberg	7
H. V. Gibbons, b Tooth	64
O. H. Smith, b Humm	21
C. G. Beasley, b Montgomery	1
J. M. Rodd, c and b Tooth	5
R. M. Knight, c Humm, b Kahlenberg	9
J. A. Rutter, not out	0
Extras	14
Total	184

Rifle Association.

The Annual Prize Meeting was held at Bisley on Wednesday, June 17th. The weather in town was thoroughly unpromising. Steady rain began on Tuesday evening, and continued until the middle of the day, while the afternoon was dull and showery. Unfortunately some of the most regular shots were kept away by hospital duties and examinations. The conditions at Bisley were much better than the weather in town seemed to indicate.

The Newton Pitt Cup was won by W. E. Wallis; the Handicap by M. K. Nelson; the "Long Range" by L. L. C. Reynolds, and the "600" by W. E. Wallis.

THIRD ARMITAGE SHOOT.

H. L. Attwater	... 94	G. A. Blake ...	... 84
H. J. Henderson	... 92	C. C. Holman...	... 68
L. L. C. Reynolds	... 91		
W. E. Wallis ...	... 87		516

Mary's, 521. Thomas's, 435.

Simultaneous shoots with schools at 200 and 500 yards. Rugby, 386; Marlborough, 375; Charterhouse, 374; Guy's, 366.

The aggregate results were:—

*1. L. L. C. Reynolds, 162.
Prize presented by Messrs. Ash.

*2. W. E. Wallis, 162.
Prize presented by Messrs. Down.

3. C. C. Holman, 146.
Prize presented by Holborn Surgical Instrument Co.

*Reynolds won on shooting off the tie.

Swimming Club.

On Wednesday, 24th inst., we met Oxford Swimming Club, and proved successful in all events bar the 440 yards, which Lattey won for the Dark Blues. Moberley, our first string, did not swim, reserving himself for the Polo. Perin, however, swam a good race, but was not able to extend the Oxford crack. In the 66 yards Roberts swam a beautiful race, and won by a touch. He should practice turning. York-Moore is a great acquisition to the Club, and his victory in the 100 yards was a well-merited one.

In the Polo our team played an excellent game, completely outclassing the Oxford side. The Team race was abandoned. Mr. P. S. Price acted as timekeeper and starter. Details:—

66 YARDS (two lengths).—C. D. Roberts, Guy's, 1; W. A. Bailey, Oxford, 2. A hard race, won by inches. Time, 42⅘ sec.

440 YARDS (thirteen lengths).—J. T. Lattey, Oxford, 1; M. Perin, Guy's, 2; K. G. Harmer, Oxford, 3. Won by 13 yards; 10. Time, 6 min., 43⅖ sec.

100 YARDS (three lengths).—R. Yorke-Moore, Guy's, 1; W. A. Bailey, Oxford, 2. A fine race for three-parts of the journey, the Hospital man finishing strongly and winning by a yard. Time, 71 sec.

POLO.—Starting from the shallow end, our men started off with great dash. Pritchard, after a good rush, passed to Glover, the latter transferred to Ball, who sent in a very warm shot. Shortly after the throw-in, Glover attempted a good back shot, which Seacombe saved. Some fast play ensued, and from a corner Pritchard transferred to Moberley, who scored with a fine back shot. Score, 2–0. Moberley scored two more goals before half-time, one from a pass from Glover, and the second from a very neat interception. Score, 4–0.

The second half saw improved play on the part of the Dark Blues, Goodchild showing up to great advantage, and scoring two goals. Shortly before time, Clarke transferred to Ball, who, after some clever play, passed to Glover, and the latter, with a well-judged throw, registered the fifth goal. Score, Guy's, 5; Oxford, 2. Teams:—

GUY'S HOSPITAL.—H. N. Eccles; R. C. Rice and G. B. Pritchard; W. T. Clarke, A. Moberley, H. Glover, and M. E. Ball.

OXFORD UNIVERSITY.—R. A. Seacombe; E. H. de Tiel and G. J. Muller; W. A. Bailey, W. A. Goodchild, J. T. Lattey, and R. S. Lindley.

Pass List.

UNIVERSITY OF CAMBRIDGE, June, 1908.—Degrees conferred.—M.B., B.C.: R. G. Chase (Trinity); M.B.: G. W. Goodhart (Trinity).

From the Gazette's Special Pathologist.

W. L. W. M., HUDDERSFIELD.—No tubercle bacilli are detected in this specimen of sputum, which is comparatively non-purulent in character.

PATHOLOGIST.

Births.

CHURCHWARD.—On June 12th, at 34, Manchester Street, W., the wife of Albert Churchward, M.D., M.R.C.P., M.R.C.S., F.G.S., etc., of South Norwood, of a son.

MUMFORD.—On June 13th, at 18, The Circus, Bath, the wife of Wilfred G. Mumford, M.B., F.R.C.S., of a daughter.

Marriage.

HOLMAN—PAYN.—On June 17th, at the Wesleyan Church, Anerley, by the Rev. H. S. Seekings, assisted by the Rev. Walter Hawkins, Ambrose Edgar Holman, to Violet, younger daughter of Walter Payn, of Anerley, and Mrs. Payn.

Death.

PURVIS.—On May 29th, at Blackheath, S.E., Prior Purvis, M.D. Lond., M.R.C.S., L.S.A., in his 96th year.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

July.

Sat. 11. 1st XI. v. Beckenham (Home).

Mon. 13. Special Clinical Lecture by Mr. Ormond (Ophthalmology) at 1.15 p.m.
Pre. Sci. M.B. (Lond.), Part I., begins.
1st and 2nd M.B. Durham begins.
2nd Part Conjoint D.P.H. begins.

Tues. 14. October Appointment List (Medical) opens.
Exams. in Histology and Elementary Anatomy, Junior Proficiency Prizes begin.
1st XI. v. Mr. Laycock's XI. (Away).

Wed. 15. School Exam. in Histology.

Thur. 16. Pre. Sci. M.B. (Lond.), Part II., begins.
Mr. Golding-Bird's and Sir Alfred Fripp's Take-in commences (Messrs. Flower and B. Wallis).

Fri. 17. Durham Finals, M.B., M.D. and M.S. begin.
Dental Histology, 2nd Year's Prize.
School Exam., Dental Microscopy.
Paper, Operative Dental Surgery, 2nd Year's Prize.

Mon. 20. First Conjoint begins
Special Clinical Lecture by Dr. Hertz (Therapeutics) at 1.15 p.m.

Tues. 21. Mr. Golding-Bird's last round.

Thur. 23. Lectures cease.
School Exam. in Anatomy.
Mr. Symonds' and Mr. Steward's Take-in commences (Messrs. Stebbing and ——).

Fri. 24. Summer Session ends.

Passim.

THE Clerk of the Weather was not kind on Wednesday. After giving us a period of unparalleled sunshine he became morose, and Wednesday was ushered in by a dull leaden sky, which afterwards disported itself in anything but a satisfactory manner. There was an intermittent drizzle until well into the afternoon, which spoilt, to a great extent, what promised to be a record Garden Party. Nevertheless, the attendance was surprisingly good, and the visitors took advantage of every lull in the showers to make the best of their way about the hospital. The attendance was increased by the many old Guy's men who had come up to Town to attend the Biennial Dinner, which was held in the evening.

THE Physiology Theatre was well filled for the Distribution of Prizes, which passed off most successfully. A full account appears elsewhere. The Dean's report was received with applause, and it certainly is an excellent one. May we congratulate Mr. Eason here on his composition and reading of it? His tactful and

elegantly-expressed hope that interest in Medical education would continue to receive support was beautifully phrased. Many improvements were spoken of. These are to be started very shortly, and we hope, in a forthcoming issue, to give our readers some details. Lord Rothschild's speech was one flattering to the profession in every way. His reference to the association of medical education with hospital work is one which every right-minded layman will endorse. When, some years ago, there was a public agitation on account of the misuse, by some of the institutions with schools attached, of funds subscribed to hospitals, Guy's stood without a blot on its escutcheon. Investigation showed that then, as at all times, the school and hospital were each on a distinct financial basis. Therefore, Lord Rothschild's remarks have special point, as far as we are concerned.

HIS references to vivisection should be read by those misguided fanatics who associate necessary and carefully-regulated experiments with barbarity, whose carping methods tend but to clog the wheel of progress and disgust all normal-minded individuals. Readers, if any of your friends, misled by false statements and gutter press agitation, are inclined to belong to this faction, show them the remarks of one of the leading men of the day, a broad-minded nobleman who is known and respected no less for his breadth of mind than for his hundred and one other good qualities.

ALL were delighted to hear of the new scholarship which had been endowed by Lady Greville. Its value is £200 per annum, and its object to encourage research in the realms of cancer. We trust it may be the means of engraving on the roll of fame the name of still another Guy's man.

IT was, indeed, characteristic of Dr. Hale White to insist on Mr. Golding-Bird proposing the vote of thanks to Lord Rothschild. It is the privilege of the senior physician to do this; but Dr. Hale White, with that thoughtfulness and courtesy which is part of him, relegated himself to the position of seconder. Mr. Golding-Bird's speech was the best we have ever heard him deliver. He could not suppress his humour, and his reference to "agitations," savouring so much of the police court, was certainly very topical.

LATER in the afternoon, when the showers had abated, the people in the Park gave one some idea of what an excellent show there would have been if the weather had remained fine. Of course the Museum attracted its usual large crowd. The wax models, so life-like in their reality, elicited many a look of wonder and not a few shudders from the sister or cousin—she of the inevitable curiosity—who would invariably approach closer to have a better view. The Nurses' Home was also a favourite show-place, likewise the lately improved Eye wards.

THE tea arrangements under the direction of the college caterer, Mr. Farnan, were excellently supervised, and it was indeed quite charming to see the visitors at their small tables in the Nurses' Colonnade in the Park and in the Colonnade proper. The musical programme performed by the Royal Meister Orchestra was much appreciated, the only drawback being its brevity.

THE Biennial Dinner, a full account of which will be found on a later page, was an unqualified success, both from a social and dietetic point of view. This opportunity of meeting old friends should be borne in mind by all those men amongst us who will soon be going out into the world, so that when they receive their notice in two years' time they will realize what a useful and happy festival this dinner is.

WE extend our congratulations to Mr. Arbuthnot Lane on his being elected to the Council of the Royal College of Surgeons. Mr. Lane was second on the poll, with 406 votes. The other old Guy's man, Dr. Eastes, polled 320 votes, and was fifth on the list. The four vacancies have been filled by Messrs. A. Pearce Gould, Lane, Haslam, and Lockwood.

MR. GOLDING-BIRD'S resignation as surgeon to the hospital was received and accepted by the Governors on July 3rd, and he was unanimously appointed to the Consultant Staff. The Governors directed that a letter should be forwarded to Mr. Golding-Bird acquainting him with this, and, at the same time, thanking him for his great service to the institution during the time he has been connected with it.

MR. GOLDING-BIRD will "go" his last round on Tuesday, 21st July. It is to be hoped that every man who can possibly manage it will be present. Take notice, old Guy's men, aforetime members of the G.-B. firm, and roll up in force. Tea will be served during the afternoon in Luke ward.

THE going-off dinner was held last Monday week, and the President and Vice-President for the ensuing three months were elected. Though the character of the dinner has been somewhat changed, it was none the less enjoyable. We refrain from commenting at length on the reforms instituted, preferring to wait and see the effect they will have on future dinners. The basis of these reforms is fundamentally correct and to be admired, but we think that the personal element is the most important factor, and as long as there are men who take opposing views as to what constitutes enjoyment, so long will these dinners retain the character so often associated with them.

THE new President is Mr. Earle, and Mr. Stebbing is Vice. To the off-going Residents who have taken their departure from us—Messrs. Goodhart, Smalley, and Walker—we offer our best wishes for every prosperity and happiness in their new walks of life. Mr. Rippman and Mr. Trethowan we will still have with us, the former as Medical Registrar, and the latter as Resident Medical Officer in Bright Ward.

MR. HUGHES is very much better, and is now well on the way to complete recovery. He does not resume his duties as R.S.O., but has been appointed a Junior Demonstrator of Anatomy, the vacancy occurring on the elevation of Sir Alfred Fripp to the Senior Surgical Staff, and Mr. Turner to the Junior. To Mr. Daw, who has been appointed R.S.O., we extend hearty congratulations.

CONGRATULATIONS to the Tennis Six, who, by beating London in the Final Cup Tie last week, have brought the Inter-Hospital trophy back to the smoking-room after a lapse of fifteen years. Mr. Earle deserves great credit for maintaining his unique record, for we believe we are correct in saying that throughout the six years he has had his tennis blue he has never lost a single set in Inter-Hospital ties.

"VANOC," in the "Handbook" of the *Referee* of June 28th, has some interesting things to say of that green-eyed monster, Jealousy. He discusses it in all its phases, from the jealousy of nations to the sordid, but none the less poignant, jealousy of Jemima Ann, when 'Liza Jane, of the next area, by superior charms, or more tasteful suppers, steals the P.C. XX. of Jemima's heart. Of course, he speaks of doctors. He asks, are doctors jealous? and answers it himself, in no uncertain way. He refers to the medicos as "a profession that clings to mystery, and still uses Latin, with an invocation to Jove, in writing its prescriptions." In fact, we are "sometimes jealous of the skilled nurse, who occasionally knows more of the disease she attends than does the practitioner under whom she works." He goes on to add that the profession "is jealous of its reputation for wisdom, when it knows no more of the facts than the man in the street," and "doctors are as jealous of each other as Indian Rajahs, who

squabble and intrigue for an increase in the number of guns with which they are saluted on ceremonial occasions."

Voila! disciples of Æsculapius, there is an indictment for you. Let us briefly survey it. Primarily, as a class, is jealousy more rampant amongst us than amongst other classes of the community? We doubt it. Of course, there is a healthy ambitious rivalry in claiming the priority of the discovery of new factors which add to the world's knowledge and alleviate the world's suffering. A certain amount of jealousy is inseparable from such aims, but it is not an excessively green-eyed monster; its countenance is milder. Why, even newspaper men display a certain rivalry in obtaining first news and original copy, and the justification of this rivalry and its concomitant jealousy — for journalists are human, too—has it such a solid basis as in the case of the medical seeker of truth?

As to being jealous of the skilled nurse, that statement needs no review. Are we jealous of our reputation for wisdom when "we know no more," etc.? Yes. But this is again a "white" variety of jealousy, a better epithet would be conservatism. And there is method in our conservatism; for know you, Vanoc, that a little knowledge is a dangerous thing. More than enough damage we see done every day by quack methods of advertising,—those advertisements that tell you where such and such an organ is, and how by such and such symptoms you can diagnose every disease from boils to cerebral tumours. And know you also, Vanoc, that the medical profession hasten to impart some of the wisdom they are so jealous of to the man in the street when by so doing the much-abused latter is benefited, *vide* the ambulance classes, the pamphlets on the feeding of infants, etc. Finally, to state that the cause of the non-appearance of reviews of a certain book—this, reader, is the basis of the whole indictment—is due to jealousy, is absurd. Seek rather, Vanoc, the reason at the publisher's or the editor's offices.

Many of Miss Florence Nott–Bower's old friends at Guy's will be interested to hear news of her. A large part of the time that has elapsed since she resigned her position as Matron here has been spent in mission work on the railways in South Africa. She came home last year, but the mission work in the Cape had proved so interesting, and her services were so keenly desired, that after a holiday spent in visiting her friends she returned to the South. Though good reports were forthcoming as to Miss Nott-Bower's general health, and to the success of the work she was engaged in, her friends were made anxious by hearing that she was suffering from what appeared to be relapsing appendicitis. The latest reports from Dr. R. C. Mullins, who has been looking after Miss Nott-Bower in Grahamstown, is that the patient is progressing very favourably after a successful operation. All her old friends at Guy's will wish her a very speedy recovery and renewed vigour to continue her exceedingly valuable mission work.

One of the greatest attractions on Wednesday last was the magnificent portrait of Dr. Frederick Taylor, which was exhibited in Addison Ward. The artist. Mr. Draper, is to be greatly congratulated in having so successfully portrayed the expression of our popular and much-respected ex-senior physician. He has caught a characteristic pose and mien which is very familiar to many of us, and, standing where it did, the portrait was startlingly life-like. Mr. Draper's work is too well known to need comment. Other examples of his art in the possession of the hospital are the portrait of Dr. Pye-Smith, and the fresco in what used to be the nurses' dining hall. Our readers will be pleased to hear that they will be afforded an opportunity of possessing an autotype of Dr. Taylor's portrait. It is to be produced at 7s. 6d., and early application, before July 27th, should be made in writing to Mr. Mills, the Librarian, or direct to the Editor.

The Presentation of Prizes.

THE Annual Distribution of Prizes took place last Wednesday before a crowded audience in the Physiology Theatre.

The Governors and Staff of the Medical School assembled in the Court Room to meet Lord Rothschild, who arrived at 3 p.m. The procession was formed, and, preceded by the mace-bearer, made its way to the Physiology Theatre.

Mr. Cosmo Bonsor took the chair, amidst applause, at 3.15 p.m., supported by the Governors and Staff. Mr. Eason (the Dean) then read his report for the year 1907–1908, which was received with enthusiasm.

DEAN'S REPORT, 1907–8.

The progress of the School throughout the past year has been very satisfactory. The entry of Students from October, 1906, to 1907, though not quite so large as in the previous twelve months, is above the average for the last six or seven years, and affords gratifying evidence that, despite increasing competition, and the general decrease in the entry to the medical profession, Guy's is maintaining its high position.

The number of students who have qualified during the past year also shows a slight decrease. At the University of Oxford, 4 students obtained the degree of Doctor of Medicine and Bachelor of Surgery. At Cambridge, 1 student took the degree of Master of Surgery, 2 the degree of Doctor of Medicine, and 10 qualified as Bachelors of Medicine and Surgery. At the University of London, 7 obtained the degree of Doctor of Medicine, and 11 qualified as Bachelors of Medicine and Surgery. At the University of Durham, 1 student obtained the degree of Doctor of Medicine, and 3 the degree of Bachelor of Medicine and Surgery.

In addition to these University degrees, 45 students gained the Conjoint Diploma granted by the Royal Colleges of Physicians and Surgeons, and 2 received the Diploma of Fellow of the Royal College of Surgeons of England.

In the Dental School the entry of students shows an increase upon that of the preceding year, and 25 students gained the Licentiate of Dental Surgery.

The School has to congratulate Dr. B. A. Richmond, who obtained the Gold Medal in the M.D. examination of the University of London, and Mr. J. R. Steinhaeuser, who qualified for the Medal; it has also to congratulate Mr. T. B. Layton on obtaining the Gold Medal at the M.S. examination, and Mr. A. M. Leeming, who obtained honours in Medicine at the M.B., B.S. examination.

The changes on the Hospital and School Staff have been numerous.

In chronicling the retirement of Mr. Golding-Bird from the active Staff, which will take effect at the end of the present Session, his colleagues desire to express to him their high appreciation of his great services, extending over a long period of years. With the severance of Mr. Golding-Bird's connection with the Hospital and School there ends a record of family service which dates back to the early part of the last century, for Mr. Golding-Bird's father was appointed Assistant Physician to the Hospital in 1843, and Mr. Golding-Bird himself was appointed Assistant Surgeon in 1875. During the whole of the time that Mr. Golding-Bird has been associated with the Hospital and School he has given it his unfailing care and interest, and it is with the greatest regret that his colleagues lose his help and presence.

Sir Alfred Fripp has been promoted to the full Staff upon Mr. Golding-Bird's resignation, and Mr. Philip Turner has been appointed Assistant Surgeon.

To fill the vacancy in the Anatomical Department, caused by Mr. Turner's appointment to the Hospital Staff, Mr. A. R. Thompson has been appointed Senior Demonstrator, and Mr. Hughes has been made Demonstrator of Anatomy.

Mr. Daw has become Resident Surgical Officer, to fill the post thus vacated by Mr. Hughes.

In view of the increase in the number of anæsthetics now given in the Hospital, consequent upon the steady enlargement of surgical practice, the Governors, acting upon the recommendation of the Medical Staff, have appointed two additional honorary Anæsthetists to the Hospital, and Dr. Shipway and Mr. H. M. Page have been elected to these posts.

Sir Alfred Fripp has resigned the Lectureship on Anatomy, and Mr. Fagge has taken his place.

Mr. T. B. Layton has been appointed Surgical Registrar vice Mr. Hamilton, retired, and Mr. C. H. Rippmann has succeeded Dr. H. C. C. Mann as Medical Registrar.

It is with great pleasure that the School has to announce that Mr. H. T. Hicks, formerly Obstetric Registrar to the Hospital, has been appointed Obstetric Physician to the Derby Infirmary, and that Dr. Wedd, formerly Assistant to the Lecturer on Bacteriology, has become Bacteriologist to the Royal London Ophthalmic Hospital.

Mr. A. N. Leeming succeeds Dr. Wedd as Assistant Bacteriologist, and Mr. Youngman has been appointed Demonstrator in the Biological Department.

Mention was made at this time last year of the action taken by the School in increasing and amplifying the teaching in the Department of Pathology, and in the interval Dr. A. E. Boycott, formerly Gordon Lecturer on Experimental Pathology, has been appointed Lecturer on Pathology to the Medical School, and is now in charge of the Pathological Department for teaching and research. Dr. G. W. Nicholson, Gull Student in Pathology, has been appointed his Demonstrator.

In the Dental School, Mr. H. C. Malleson, who has recently been attending the Dental Practice of the University of Pennsylvania as Travelling Scholar, has followed Mr. J. E. Spiller as Demonstrator of Practical Dentistry.

The success of the arrangement for admitting pupils for the period of mechanical training in the Dental

School has been so great that the new laboratory accommodation, which was mentioned at this time last year as about to be ready in the following October, has already proved inadequate, and it is proposed still further to increase the accommodation for students taking this part of the Dental curriculum by the commencement of the ensuing Winter Session. At the same time, in order to increase the facilities afforded to Dental Students who wish to take the first professional examination in Dental Surgery, arrangements have been made that in future the courses of instruction in Dental Mechanics and Metallurgy shall be given twice a year instead of in the Winter Session only, as was the previous custom.

During the past year the Students' Residential College, which was erected on ground belonging to the Hospital by the Medical School in 1889, has been taken over by the Governors and leased to the Medical School. This arrangement will prove of great advantage both to the Hospital and the Medical School, and the Staff gladly avail themselves of this opportunity of thanking the Treasurer for his services in the negotiations.

The accommodation for Operative Surgery in the Anatomical Department having become inadequate to the most recent requirements, the School proposes to rebuild this part of the School during the vacation, in order that a thoroughly well-equipped and modern department may be available for students before the commencement of the Winter Session; during the same period it is also proposed to make further renovations and additions to the Biological Department.

It is with great pleasure that the School has to announce that the receipts from students' fees have increased considerably during the past year, and that as a result the financial position of the School has much improved. At the same time, it must again be pointed out that the expenses of medical education, consequent upon the increasing complexity of the medical curriculum, make it impossible for a large educational establishment, such as the Medical School attached to Guy's Hospital, to be carried on without endowment.

As has been announced before, the Medical School receives no subvention, either directly or indirectly, from the Hospital funds. It is felt, therefore, that the case for the endowment of medical education and research is so strong that appeal can confidently be made to the public direct for the necessary support.

It is with great gratitude that the School has to acknowledge many bequests to this fund in past years, and it has this year to thank Sir W. Cameron Gull, a Governor of the Hospital, and a previous benefactor of the School, for further evidence of his interest in its welfare in the transference of his annual subscription from the Hospital to the Medical School Fund.

Once again it is the urgent duty of the School to call attention to the fact that though in the past years every effort has been made by the Staff to maintain the School at the highest level of efficiency, much more remains to be done if the burden thrown upon them is not to become insupportable. It has been pointed out in previous years that it is inexpedient to increase the students' fees at the present time of general financial depression, since an increase in fees would make the cost of medical education too high in proportion to the limited income to be obtained in the ordinary practice of the profession, and, moreover, that the competition of the Provincial Schools, which are generally so well supported by local patriotism, would probably render such a policy nugatory.

Hence this report must end, as it has ended for many previous years, in a further appeal for donations to the fund for the Endowment of Medical Education and Research, in order to maintain the Medical School of Guy's Hospital in a manner worthy of its high traditions.

The Treasurer then called upon Lord Rothschild to distribute the Prizes to the successful students. The following is the list of successes :—

OPEN SCHOLARSHIPS IN ARTS.—Cedric Sydney Lane Roberts, Cheltenham College, £100. George Dunluce Eccles, Plymouth Technical School, £50.

OPEN SCHOLARSHIPS IN SCIENCE.—John Finlayson Mackenzie, Preliminary Science Class, Guy's Hospital, £150. Richard Douglas Passey, Preliminary Science Class, Guy's Hospital, £60. Thomas Izod Bennett, Preliminary Science Class, Guy's Hospital, Certificate. George Edward Genge-Andrews, Preliminary Science Class, Guy's Hospital, Certificate. Skene Keith, Preliminary Science Class, Guy's Hospital, Certificate.

SCHOLARSHIP FOR UNIVERSITY STUDENTS.—John Godfrey Saner, B.A., Caius College, Cambridge, £10.

OPEN SCHOLARSHIPS IN DENTAL MECHANICS.—October, 1907, Charles Holme Barnett, £20; May, 1908, Harold Harrison, £20.

JUNIOR PROFICIENCY PRIZES.—Frank Cook, £20. Edward Gustave Schlesinger, £15. Abdel Hamid Gool, £10. Herbert Leslie Hopkins, Certificate.

THE BEANEY PRIZE FOR PATHOLOGY (1907.)—Kenelm Hutchinson Digby, £34. Thomas Edmund Ashdown Carr, Certificate.

THE MICHAEL HARRIS PRIZE FOR ANATOMY.—Edward Gustave Schlesinger, £10. Abdel Hamid Gool, Certificate.

THE WOOLDRIDGE MEMORIAL PRIZE FOR PHYSIOLOGY.—Frank Cook, £10.

DENTAL PRIZES.—First Year's Students.—James Alfred Wyllys Stuart, £10.

PRACTICAL DENTISTRY PRIZE.—William Archer Hodgson, £10. Hubert Ernest Shepherd, Certificate.

GOLDING-BIRD GOLD MEDAL AND SCHOLARSHIP IN BACTERIOLOGY.—Hugh Stott, £20. Herbert Cubitt Lucey, Certificate.

TREASURER'S GOLD MEDAL FOR CLINICAL MEDICINE.—Edward Leslie Martyn Lobb.

TREASURER'S GOLD MEDAL FOR CLINICAL SURGERY.—Arthur Norman Leeming, Medal. Gilbert Francis Syms, Certificate.

Lord Rothschild then delivered the following address, which was punctuated with applause by those present:—

LORD ROTHSCHILD: This is not the first time I have had the honour to speak in Guy's Hospital. The last time I was here, Mr. Treasurer, I think that you were canvassing for funds, and owing to your able management the hospital is now financially in a very strong position, with no deficit. This in itself is a most satisfactory state of things, but the foundations on which the finances of a hospital rest are somewhat insecure, so that hospitals and similar charities cannot always expect to be in this happy condition. The object of this meeting, however, is not to consider the finances of the hospital, but to wish success to those medical students who have been honoured in the examination, and success in their profession to those also who have not been successful to-day. It would be ridiculous on my part to attempt to explain the advantages of the great schools of medicine and surgery, and I should think it is apparent to all that a school of medicine and surgery cannot be a success if it is not an adjunct to a hospital. Of late years a new school of thought has arisen, both in this country and on the Continent, which criticises the arrangements which have been in vogue in the hospitals for so many years, and gives three chief reasons why schools of medicine and surgery should be divorced from the hospitals. To my mind these reasons are essentially trivial. One is that patients in a hospital derive no advantage from the students, and that their ease and comfort are interfered with when an eminent physician explains their condition to them. Of one thing I am certain, and that is that the students who listen to the master are often able to help the patients in the absence of the great man who has instructed them. A second reason is that the course of medicine and surgery is so mixed up with vivisection that students become hardened and cease to be humane. The third reason is the cruelty inflicted on animals operated upon. Under anæsthetics I do not think that animals suffer much at all; but even if they did, the advantages derived from the experiments by surgeons and others are of great benefit to humanity. Those interested in the welfare of the school and in the progress of the students will be glad to hear that the Honourable Mrs. Ronald Greville has founded a research scholarship of £200 in memory of her deceased husband, the students being required to devote themselves to some of the problems connected with cancer. I will conclude by wishing success to the students here to-day, to those who have had the privilege of winning a prize, and success in their career to those who have not.

Mr. Golding-Bird, who was received with great applause, then moved a vote of thanks to Lord Rothschild, couched as follows:—

Mr. GOLDING-BIRD: By a great act of courtesy, which I very much appreciate, I have the honour to propose the vote of thanks to Lord Rothschild. It is the usual custom for the vote of thanks to be proposed by the Senior Physician, but for a reason which will be sufficiently obvious to you, the task has been entrusted to me on this occasion, and I thank Dr. Hale White for his thoughtfulness. After 33 years' service, it is very kind to let a man down gently, and I can truly say that I have given the best of my life to the hospital. I regard the presence of Lord Rothschild to-day as most important. Although he is neither a Governor of the hospital nor officially connected with it, he has united us to him by bonds of gratitude which I hope will never be forgotten. At the time of our greatest distress he came forward with many thousands of pounds, and laid the foundation of the causeway along which we have since been travelling, guided by our Treasurer, and we now stand in a pecuniary position which I for one never expected to reach again. Lord Rothschild is here to-day as one of the greatest laymen in the Empire. His position here is purely academic, and emphasises the awakening interest of the public in medical education, and, as you have heard from the Dean, we are already talking of appealing to the public for aid in medical education. I had almost said that we were agitating, but agitation now-a-days is so close to the police courts, that I will not use the term. It is not right that the charity which broods over the hospitals should have to extend its wings over the schools. The latter is a purely business matter, and the services which we give to the hospitals ought not to be demanded of us for the schools. The public may ask why they should educate other people's children, or educate a man whom they afterwards pay when he comes to cure them. The proudest thing connected with the medical education which we give, is the prevention of disease, and the public have not yet learned to estimate the immense pecuniary saving to them which results from the fact that our men, when they leave the hospitals, are now masters in the prevention of disease, and are more proud of having stopped an epidemic of scarlet fever than of the fees which they might have received without this knowledge of the prevention of disease. I never hear any man complain now that an epidemic is not in a flourishing condition. Upon these grounds I found my own belief that the public should be called upon to take an interest in medical education, and I claim that Lord Rothschild is here to-day in no other capacity than as the greatest layman of his time, adding authority and weight by his presence to the view that the public should take a very substantial interest in the education of medical students. It is not quite true that his sole connection with the hospital is his kindness of heart. Perhaps you do not know how much we owe to Lady Rothschild, to her kindness in the wards and to the nurses, and by the profound interest in the nurses which she has shown by the fact that she has retained the presidency of the Nurses' Fund, which she has only recently resigned, for sixteen years, and has never voluntarily missed the quarterly meeting. I will now ask you to propose a vote of thanks to Lord Rothschild. (Applause.)

Dr. HALE WHITE, in seconding the vote of thanks to Lord Rothschild, said that he could not imagine anyone doing a kinder thing for any institution than to preside at a meeting and make a speech, and what Lord

Rothschild had done deserved the warmest thanks. It showed appreciation of the schools and hospital. (Applause.)

Lord ROTHSCHILD, in returning thanks for Lady Rothschild and himself, said that he wished not only for the prosperity of the hospital, but also for the Medical School and all connected with it. (Applause.)

Those present then inspected the various parts of the hospital, all of which were thrown open.

In Lighter Vein.

THE POCKET GRAY'S ELEGY.

(Written near the Imperial Institute on the first Monday in any July.)

"Time's up. Stop writing," is the order of the day,
"Invigilators" hie them home to tea;
The ploughed man homeward plods his weary way,
While I take refuge in the A.B.C.

Now looms the dear old District into sight,
And all the air a dusty fragrance holds,
For there the motors wheel their droning flight,
And constant "pip-pips" fill the Cromwell Road.

And mark how yonder fancy-socked young man
In forceful words does to his pals complain
Because examiners do all they can
To sound his sadly understocked young brain.

The cocksure boaster and the modest soul,
The slacker and the slogger, soft and wise,
Await alike th' inevitable hour:
The Pass List's story causes oft surprise.

EPITAPH.

(In the District.)

Here hangs upon a strap below the earth
A Youth, to Fortune and to Brain unknown:
Fair Science frownéd at his humble birth,
In Anatomy they pipped him on a bone.

A. N. C.

Nursing News.

MATRON'S OFFICE.

On April 21st, Sister Theatres, Miss J. Crerar, was transferred to the Preliminary Training School, and Miss Ethel Edwards, who completed her training in April, 1907, was appointed Probationary Sister in charge of the Theatres.

Sister Ethel, Miss E. Clifford, Second Home Sister, was appointed Sister in charge of the Actinotherapeutic Department on April 21st.

On April 23rd, Sister Out-patients, Miss E. Fraser, left the hospital to take up nursing work in Canada, and Miss M. J. Lyons, who entered as a Probationer in January, 1905, was appointed to succeed her as Probationary Sister in charge of the Out-patient Department.

On May 29th, Miss L. Greenall, who entered the hospital as a Probationer in November, 1904, was appointed Probationary Medical Night Sister.

Miss M. Atkey, who had been Sister of Addison since October, 1905, left the hospital on June 5th. Sister Naaman, Miss E. M. Cheesman, was appointed Sister in charge of Addison ward. Miss Violet Lulham, Surgical Night Sister, was transferred to Naaman ward. Miss Jessie Crerar, Pupils' Instructress, was appointed Surgical Night Sister, and Miss A. R. Baker, who completed her three years' training in September, 1907, was appointed Probationary Sister in the Preliminary Training School.

On April 24th, Nurse Hogg, Head Nurse in John, was transferred to the Theatres. Probationer Kiddle was appointed Head Nurse in Miriam, and Probationer Harrington was appointed Head Nurse in John ward.

On April 30th, Nurse Hambro, Head Nurse in Bright ward, left the hospital on completion of her three years' training, and Probationer Hill was appointed to succeed her as Head Nurse.

On May 11th, Nurse L. Wood, Head Nurse in Stephen, left the hospital on completion of her three years' training, Nurse Horton, Head Nurse in the Out-patient Department, was appointed to succeed her as Head Nurse, and Probationer Harrison was appointed Head Nurse in the Out-patient Department.

On June 10th, Nurse M. Lloyd, Head Nurse in Mary, was appointed Staff Nurse in the Isolation wards, and Probationer Wakeling was appointed to succeed her as Head Nurse in Mary ward.

On June 15th, Nurse Hodgkinson left the hospital on completion of her three years' training, and Probationer Foley was appointed to succeed her as Head Nurse in Martha ward.

Nurse Pilcher and Probationer Morrison have been appointed Head Nurses in Luke ward.

Diagnosis of Acute Abdominal Conditions

Treasurer's Prize Essay, Physical Society, 1908.

By R. G. CHASE, M.B., B.C., M.R.C.S., L.R.C.P.

ERRORS in diagnosis are more frequently due to errors of omission rather than to errors of commission. This very common-place remark is only too true of any abdominal condition, for it cannot be too strongly urged that, when trying to make a diagnosis in any of these cases, no symptom, no system or group of systems should be left unexamined.

The patient must be thoroughly and systematically overhauled if we would wish to avoid making mistakes, or, at any rate, making as few as possible. In some conditions, with only our present means of investigation, it is not possible to make a definite diagnosis; we can only indicate the probability of our case being one of a certain group. It will be the object of this essay to indicate as far as possible how we can make a diagnosis when our patient comes before us.

"Acute abdominal conditions" is here taken to indicate those cases in which the symptoms, either by their sudden appearance or by their sudden intensification, cause the patient to seek for immediate relief. The symptoms of many abdominal diseases vary very much according to the period of the disease in which they are seen. Thus jaundice may be due to simple catarrh or to suppurative pylephlebitis. The diagnosis in such cases becomes of great prognostic significance.

We will now imagine that we have been called to see a patient who is complaining of sudden abdominal pain:—Appendicitis, perforated gastric ulcer, colic, etc., will flit across our mind.

Before settling the diagnosis to be appendicitis because the pain is in the right iliac fossa, we will thoroughly examine the patient as if to write a medical report. The age of the patient may be important, for, whilst most diseases may occur at any age, there are some which are extremely common within certain limits; thus intussusception may occur in adults, but it is much more common in children under two years; gastric ulcer has occurred in a fœtus, but it is infinitely more common between the ages 20–40.

The sex of the patient must influence the diagnosis, for with adult women we must consider the possibility of one or other of those diseases, peculiar to women, which are acute in character, *e.g.*, ectopic gestation, dysmenorrhœa, perimetritis, etc. The occupation of the patient is frequently the sign-post to the diagnosis. If a worker in lead suffer with abdominal pain, we suspect lead colic. The anæmic waitress is expected to possess a gastric ulcer. The coachman or the butler frequently feel the effects of gall-stones. The personal history may be very important. If our patient is complaining of diarrhœa, and we find he suffered from dysentery abroad, we have a clue to a possible diagnosis. It is very important with female patients, if mothers, to find out if they nursed their children when born; and, if so, for how long lactation continued.

Previous diseases or accidents must be taken into consideration; a previous laparotomy will suggest adhesions, or bands, between the coils of intestines to account for pain.

The history of previous attacks is of great importance when diagnosing appendicitis. Previous renal trouble would lead one to think of uræmia. In this way an innumerable list could be made out.

We now come to that which the patient has to tell us about the present trouble. We must find out if the onset was acute, or if the symptoms previously bearable became unbearable. If the patient complains of pain, we must find out when it first started; the kind of pain it is, whether dull aching, or sharp shooting; whether it is colicy in nature; the position of it; whether relieved or increased by pressure; whether deep pressure is more painful than superficial pressure; if the pain is sufficient to keep the patient awake at night; if it causes the patient to vomit; whether micturition or defæcation is painful too. If the pain occurs after food, we must find out how long after food; if the patient is ever sick without the pain, and, if so, the character of the vomit; if there is any flatulence, hæmatemesis, loss of appetite, etc.

With regard to hæmatemesis in children, it should be remembered that a child always will swallow its expectoration; and if this is blood-stained, the subsequent vomit will also be blood-stained. This may suggest hæmatemesis when the real trouble is hæmoptysis.

We must inquire about the patient's bowels, if there is any—1. Constipation. 2. Diarrhœa. 3. Blood; if so, the colour: bright red, dark red, black. 4. Mucus. 5. Casts or sloughs. 6. Colour of stools: *a.* Clay colour; *b.* Black; *c.* Brown. Patients with black stools have often been taking bismuth or iron, etc., in their medicines.

We must inquire about the patient's urine, as to the quantity passed, the frequency of micturition, as to whether the act is painful, as to any abnormality in colour, deposits, etc. In women it is very important to inquire about their obstetric history, whether menstruation is regular, whether they have missed any periods recently, whether they have been suffering from any discharge, and whether they have had any previous miscarriages.

So far, we have been relying on information obtained from the patient or his friends. We must now attempt to obtain positive evidence ourselves, which we try to work in with the history already given. It will not be necessary to go over the various signs which we shall find when we examine patients suffering from various conditions at this stage; they will be described when the conditions are discussed later. It will be sufficient to indicate here some of those symptoms which we can take in by observation whilst obtaining the patient's account of his trouble. Much valuable information will be obtained by merely watching the patient. Probably the first thing that will attract our attention is the *colour*, especially if it is at all abnormal.

The patient may be: *a.* flushed; *b.* cyanosed; *c.* pale; *d.* yellow; *e.* dark.

a. Flushed.—Patients who are in a high fever, with temperature 101 to 103, have a particularly bright flush on their cheeks and ears. Their pulse rate will be increased, and their respiration will also be markedly quickened. If our patient is flushed when we see him, we shall think of some specific fever, such as scarlet fever or typhoid; or else some septic condition, such as a pyæmia or septicæmia, although with these cases there is a peculiar sallow aspect superadded. If the pulse rate is slow in relation to the temperature, we shall suspect typhoid; if the respiration rate is increased above the normal temperature relation, we must consider early pneumonia. Influenza must also be thought of, as the abdominal type is exceedingly painful.

b. Cyanosed.—In these cases the patient is not obtaining sufficient oxygen. Therefore, if we dismiss such conditions as asphyxia due to lack of oxygen, or laryngeal obstruction, we come to three great organs in any of which the primary mischief may be present; *i.e.*, heart, lungs, and kidney. If on abdominal palpation we find a pulsating liver, with its accompanying pain, we shall find evidence of right-sided heart failure; we thus account for the right-sided abdominal pain. In the same way we must investigate the lungs and the urine.

This brings us to a parenthesis on the question of the examination of urine, and the diagnosis of genito-urinary disease. Beyond the chemical tests for albumen, sugar, acidity, or alkalinity, there are a certain number of instruments which should certainly be used if mistakes are to be avoided:—1. The Hydrometer, to measure the specific gravity. 2. Microscope, to discover casts, crystals, etc. 3. The Sound. Is there a vesical calculus? 4. The X-rays. Is there a renal or vesical calculus? 5. The Cystoscope. Is there any cystitis? Are both kidneys working? Is there a stone? Is there any growth? 6. The Segregator. Are both kidneys equally diseased? Is the pus coming from the right or left kidney, or both? If these are all used, errors in diagnosis will be rare.

We must now return to our colour classification.

c. Our patient may be *pale*. There will, of course, be different degrees of pallor. The sheet-whiteness of a patient who is bleeding internally, or who has recently lost much blood, is very conspicuous, and could not be overlooked. Again, patients with advanced malignant disease show a peculiar pallor, which is frequently very suggestive, to say the least of it. We must not forget under this heading the "large white kidney" patient with his pale swollen face.

d. The *jaundiced* patient does not escape notice, and immediately suggests something wrong in the liver region of the abdomen. Jaundice may be due to:—1. Simple catarrh. 2. Gall-stones in the common duct. 3. Malignant disease of the liver. 4. Cirrhosis. 5. Acute septicæmia due to such organisms as the streptococcus longus. 6. After operations (*e.g.*, appendicitis), adhesion formations. 7. Suppurative pylephlebitis from possibly primary appendicitis, etc.

We must now endeavour to decide by subsequent examination which is the more likely of these suggestions.

e. Dark.—Some patients almost resemble a nigger. They have a darkly-pigmented skin which is natural to them, but others become pigmented, some through taking certain drugs, such as arsenic or silver; others, again, become pigmented from certain diseases, such as malaria or Addison's disease.

Patients with Addison's disease frequently have abdominal pain; it would be very important to prevent an exploratory laparotomy on this

patient, and his colour would be the guide to the real diagnosis, taken, of course, in conjunction with his other symptoms.

Another extremely common sign of an acute abdominal condition which we shall observe directly is the typical anxious and pinched expression on the patient's countenance. He is quick to hear and to interpret any opinion that may be expressed within his hearing, and even though one may have purposely moved away from his bed he will endeavour to estimate the gravity of his illness by the countenance of the medical attendant. He is intensely worried over his illness. This activity of cerebration persists up to the end, if the case terminates fatally.

It is often possible to say at a glance that a patient is suffering from loss of fluid; this is particularly noticeable in small children suffering from enteritis. It is an important observation which should not be overlooked.

It is not possible in an essay to give the various combinations of signs that we may find associated to illustrate the various acute abdominal conditions. These will best be dealt with when considering the diagnosis, differential or otherwise, of the common acute diseases; therefore we will now proceed to those acute conditions which have their origin in the stomach.

The commonest disease of this organ is probably gastric ulcer. We shall probably be called upon to treat this patient, if he is suffering from the acute stage of ulcer, because he suddenly vomited blood. We shall obtain a history of pain after meals, sometimes a long time afterwards. In all probability our patient will be an adult between the ages of twenty and forty. The disease is commoner in females than in males. We shall expect to find the stomach region tender on pressure, with probably a small area of hyperæsthesia in the region of the epigastrium. Our patient will also probably tell us he has frequently been sick, but he may not have vomited blood before, or even at all. Hæmatemesis occurs in only one-third of all the cases of ulcer.

The diagnosis is in many cases very easy; in others it cannot be made without careful watching, whilst in others again it is well-nigh impossible. Before we decide that our patient has an ulcer we must exclude other diseases in which hæmatemesis occurs. Thus in children it is important to remember that blood from the gums, tonsils, nasopharynx, or even from the mother's cracked nipples, will be swallowed and vomited. In this case, however, the quantity of blood will be small compared with the amount vomited when the cause is an ulcer. Actual bleeding from the stomach takes place in many other conditions besides ulcer. Most of these are sufficiently obvious not to cause difficulty in diagnosis if a thorough examination be made. Thus we must in this way exclude heart disease, nephritis, cirrhosis, gall-stones, hæmophilia, and the general blood diseases, such as the anæmias and the leucocythemias, purpura, scurvy, and poisoning. Some patients bleed from the stomach after an abdominal operation, such as gastrojejunostomy.

We must now come to a more difficult diagnosis. Is the patient suffering from malignant disease? If this be so, we shall not expect to obtain a long history of indigestion. The age of the patient will be over forty. If the pain and discomfort have already lasted eighteen months, that alone is in favour of ulcer; on the other hand, the presence of secondary growths elsewhere is conclusive evidence that the primary trouble is malignant. A profuse hæmorrhage of bright red colour is in favour of an ulcer. No reliance can be placed on the presence or absence of a palpable tumour. Cachexia is in favour of growth. Gastric crises should be excluded without difficulty.

There are some cases, however, on record in which mistakes have been made owing to the lack of the other signs of locomotor. The vomiting may simulate ulcer; hæmatemesis is very rare; the pain is not relieved by vomiting, whilst this is almost always so with ulcer.

In anæmic dyspepsia, there is no localized painful area; vomiting takes place independently of meals. The hæmatemesis of these cases has been called gastrotaxis by Dr. Hale White.

Gastralgia may simulate ulcer in the intensity of the pain, which occurs immediately after food. Again, there is more pain after liquids than solids; there is no hæmatemesis, and vomiting occurs occasionally, with some relief from the pain.

Gall-stones may cause similar symptoms to ulcer, especially when there is severe localized pain. We must note, however, that the pain is not in the epigastrium except when the stone is in the common duct. We then get jaundice. The pain may last many hours and subside suddenly. Other distinguishing signs are the presence of pyrexia with or without rigors, the presence of profuse perspiration, and the presence of bile in the urine very early.

Duodenal ulcer can usually be distinguished from gastric ulcer except in a few cases. In duodenal ulcer the pain is more deeply situated

and less severe, occurring three to five hours after food. Vomiting bears no relation to food, and may be alkaline, and contain bile. Malæna is a prominent symptom.

A gastric ulcer may perforate either in its acute stage or early chronic state. This is said to occur in 6·5 per cent. of all cases of ulcer. Considering the more frequent occurrence of ulcer in females than in males, perforation will be the more common event in a female subject, but it is more likely to occur in men over forty than in any other patients. Of 200 ulcers, 190 were in the posterior wall, of which four perforated. Ten were in the anterior wall, of which eight perforated.

The result of perforation in a patient may be death from collapse after a few hours, or more commonly a sudden severe pain of an agonising character situated first of all in the epigastrium or in the right iliac fossa, and later spreading over the abdomen. The pain may be continuous or of a colicy nature, with collapse. The pulse will become small in volume, quick and thready, but occasionally, for some little time after the operation, it may remain slow and of moderate tension. The patient's face is usually pale and pinched, and the body cold with a clammy perspiration. The voice is feeble. Respiration is frequent, and only the ribs are moved. The temperature in the early stage is subnormal, and only becomes raised if peritonitis supervenes. The tongue is dry, the patient is thirsty. Vomiting occurs in 40 per cent. of the cases. The diagnosis here depends upon two factors—*a*. Has the patient peritonitis? *b*. Did the ulcer cause it?

The question as to peritonitis will be considered later when dealing with that heading, and we must endeavour to settle the question of the ulcer by the history we can elicit from our patient.

Before considering rather fully the diagnosis of appendicitis, we will take rather briefly some of the less common acute and subacute diseases of the small intestine. Cases are on record in which a baby begins to vomit soon after birth, and continues to do so until death occurs within five days. There is no bile in the vomit, which is first of all clear, but becomes blood-stained later. In this case congenital occlusion of the duodenum is probably present.

Enteritis is an acute disease which gives rise to signs of obstruction; this also is of rare occurrence.

Sudden hæmorrhages giving rise to hæmatemesis or melæna, or both, may occur in such diseases as infective endocarditis, pyæmia, thrombosis of the mesentric vessels, purpura (ulceration may occur in these cases, too), strangulation, and in all forms of ulcers, whether tubercular, syphilitic, peptic jejunal, leukæmic, and typhoid. We shall not have much difficulty in diagnosing some of these conditions. Infective endocarditis will be indicated by the condition of the heart, the patient's temperature with hæmaturia, etc.

Pyæmia will again have constitutional symptoms with abscesses.

Thrombosis of mesentric vessels would be a bold diagnosis, but here other source and cause of the thrombosis must first of all be discovered. Purpura will be indicated by the character of the rash. Strangulation will give signs of obstruction, with possibly a localised tender swelling.

Typhoid must be diagnosed on the constitutional signs of that disease. Syphilitic ulceration is very rare. Peptic jejunal ulcers occur occasionally after gastro-jejunostomy operations.

We now come to the commonest acute disease of the abdomen—inflammation of the vermiform appendix. The symptoms of this condition vary enormously with the severity of the attack; so that, on the one hand, we find patients with merely symptoms of discomfort on the right side in the region of the right iliac fossa; whilst, on the other hand, others are extremely ill with pyrexia, vomiting, thirst, constipation, and an extreme degree of local tenderness with marked rigidity. A lump may or may not be palpable, depending upon the condition of the abdominal wall, upon its rigidity, and upon its layers of fat. When a rectal or vaginal examination is made, the right side is usually more tender than the left; but, on the other hand, in those cases where the appendix is long and is lying over the brim of the pelvis, tenderness and even a lump may be felt bulging through the left side of the rectal or vaginal wall, and the case is still one of appendicitis. The lump is inflammatory thickening, with matted coils of intestines around an inflamed appendix. This disease must be diagnosed from many other diseases, and one's only safeguard is to make a thorough examination of every system. It is the lot of most physicians, at some time, to ask a surgeon to perform laparotomy on a patient who is suffering from pneumonia, the diagnosis being appendicitis. The pain in the right iliac fossa, with tenderness, is referred along the lower intercostal nerves. The pulse is quick, the temperature is up to 102. The patient has been sick, and possibly had a rigor. Respiratory

symptoms should, however, be present. The patient will be breathing too rapidly for his temperature and pulse rate. The writer has, however, seen a case in which the respirations were 55 per minute, and peritonitis, due to appendicitis, was present. In this case, there were signs of old pneumonia. If we can make the patient take a deep breath, we may hear a rub at the right base. There will also be no local tenderness on rectal (or vaginal) examination. Peristalsis can be heard to be going on by auscultating the cæcal region. There will be no free fluid in the abdomen. It must be remembered that it is better to operate upon a patient with pneumonia than to leave a patient with peritonitis unoperated upon, because there is the possibility of pneumonia being present. In this connection we must not forget that the two do occur together. The peritonitis is usually, however, very acute, so that there will not be much question about it being present. In typhoid fever we sometimes get great pain in the cæcal region, possibly due to typhoid ulceration of the appendix, so that we should exclude the diagnosis of typhoid before being quite certain of our "simple" appendix. In children, an acute arthritis of the right hip will simulate appendicitis; we must, therefore, examine the hip joint for disease, and note if the child persists in keeping the right thigh slightly flexed.

The pain of a duodenal ulcer is usually higher up than that of appendicitis. We shall have here also a history of pain an hour or so after meals, with possibly malæna. Urethral pain frequently simulates appendicitis; the pain is more lumbar in origin, and on examining the urine, blood, pus, or crystals may be found to indicate the kidney as the source of trouble.

Appendicular colic is not easy to distinguish from appendicitis at first sight. The constitutional symptoms of the latter disease are not, of course, present, but as they are frequently absent in true appendicitis we are not much nearer the diagnosis. In these cases we can frequently obtain a history of some indiscretion in diet a few hours previously. The symptoms pass off in about twenty-four hours. This would not occur in appendicitis.

We must now consider the question of *colitis* being present. In this case there will be no increase in pulse rate, and no rise in temperature. Patients with mucous colitis pass mucus in their stools (chronic appendicitis causes the same symptom). Patients with membranous colitis are tender all over the colon, and not only in the appendicular region. We must exclude lead colic by the absence of the other symptoms of lead poisoning, such as:—the drop wrist, the blue line on the gums, relief of pain by pressure, granular kidney, gout, etc.

Inflammation of the gall bladder often co-exists with appendicular trouble. The pain in this case is referred eventually to the gall bladder region. The appendicular region will not be tender if only cholecystitis is present. There will probably be a history of gall-stone trouble previously.

In adult women we must exclude, if possible, diseases of the pelvic organs. Right-sided ovaritis is impossible to separate from appendicitis without an exploratory operation.

Other possibilities are:—Suppurating ovarian tumours, pyosalpinx, twisted ovarian pedicle. These all give the lump and tenderness on the right side, with a rise in temperature and increase of pulse rate. If we can get a history of vaginal discharge, with possibly some menorrhagia, we may suspect the pelvic organs to be at fault. Perimetritis, or parametritis, we should suspect if the trouble came on after some local infection. The pain of dysmenorrhœa may be so intense as to simulate appendicitis. Its occurrence at monthly periods would make one suspect the condition. Rupture of an ectopic gestation may simulate appendicitis.

If the case be of the acute variety, the blanching which rapidly occurs will make one suspect the gestation. Inquiry as to the length of amenorrhœa may give some confirmatory evidence. The pain of a hæmato-salpinx on the right side closely simulates appendicular pain. If the gestation result in a tubal mole, a lump will be felt in Douglas's pouch which may be mistaken for an abscess. There is some rise in temperature and increase of pulse rate in these cases, so that these symptoms are not necessarily in favour of appendicitis.

Finally, there are many lumps which might be felt in this region which are not abscesses or adhesions round an inflamed appendix. The commonest lump is probably—especially in women—due to masses of scybala. Others are:—Pyonephrosis; growth of the cæcum and tubercular or actinomycotic accumulations in this region; intussusception, or inflamed glands. Pyonephrosis may be distinguished by examining the urine. Growths of the cæcum and scybala will not give constitutional signs. Tubercular trouble will not be acute.

Intussusception will be discussed later. It will not give many signs of appendicitis (simple).

Inflamed glands and actinomycosis may cause great difficulty; the latter is, however, very

uncommon, whilst the former is not of very frequent occurrence.

So far, we have been considering simple appendicitis. We must now imagine the inflammation to spread and to have set up a peritonitis by the time we see the patient. The seriousness of this condition is at once apparent. Instead of a localised tender area which does not move on respiration, the whole abdomen will be found to be tender, deep pressure being more painful than superficial pressure. The abdomen does not move on respiration; it may be distended. It may be possible to detect free fluid in the abdomen. Micturition and defæcation will be painful. The face will be pinched, with an anxious expression and probably sunken eyes with dark rings around them. The tongue will be dry. The patient will vomit occasionally; he will not be able to pass either fæces or flatus in the later stages, no action being produced by turpentine enemas. No peristaltic waves will be seen through the abdominal wall, and no gurgling when the abdomen is listened to with a stethoscope.

The temperature may or may not be raised. The pulse is usually quick—small volume. It is always so in the later stages, but if seen early there may not have been time for the infection to have had its complete action on the circulation. Another important symptom which results from the feeble circulation is that the hands and feet are cold.

The most important condition to diagnose peritonitis from is intestinal obstruction. This in the early stage is quite easy, but when peritonitis has lasted some time, and paralysis of the gut has supervened, the symptoms and signs resemble obstruction to a marked degree. The chief distinguishing features are, however, that with peritonitis the temperature is usually slightly raised, the pulse is accelerated and thready, there is a leucocytosis, abdominal tenderness becomes universal, and there are no peristaltic movements visible. This will be considered again when intestinal obstruction is under discussion.

In all cases of abdominal pain the question of *neuralgia* should be thought of. Some of the abdominal neuralgias are very difficult to diagnose. We may have a neuralgia of almost any organ in the abdomen. The pain is most intense. The attacks may last a few minutes to a few hours. Vomiting may occur. Under this heading we must consider gastric crisis of locomotor. If the nervous system be examined, we shall not be likely to mistake the lightning pains of this disease for anything else, for the constitutional signs of locomotor will almost invariably be found to be present. The rarer neuralgias are definitely thought to be a true neuralgia, and not simply a neurosis.

In hepatic neuralgia the attacks of pain may end in vomiting, the liver may be tender, but is not enlarged. This condition is very difficult to diagnose from gall-stones.

Enteralgia is not very infrequent, but is very terrible, starting with a piercing, agonising, prostrating pain leading to collapse. It is often associated with gout. The pain starts at the umbilicus. The belly may be blown out, or retracted and tense. We must be careful not to confound this condition with lead poisoning or umbilical hernia.

Nephralgia may simulate stone even to hæmaturia. It should never be diagnosed before an exploratory operation, as a stone may be present as well in these patients.

The abdominal pain of spinal caries will not be difficult to account for when we have discovered the existence of the caries. This pain is referred along the intercostal nerves corresponding to the lesion.

We now come to the diagnosis of colic in its various forms. The chief distinguishing feature from peritonitis is that the pain of colic is relieved by pressure, whilst that of peritonitis is increased by pressure. The fallacy of this distinction is exposed when organic disease and colic co-exist. Patients in these cases have anxious countenances and clammy skin. The abdomen is hard and rigid; there may be nausea or actual vomiting, or possibly a constant desire to micturate. It is important to inquire if any irritating food has recently been eaten. When colic occurs in the cæcum it is liable to be mistaken for appendicitis. The diagnosis here is extremely important. If the patient is seen early it is impossible to diagnose intestinal obstruction from it; here the effect of a purgative must be watched, but should not be repeated.

The early stages of a perforation are very similar to colic, but they pass on to peritonitis and obstruction. We must endeavour to distinguish these troubles by remembering that in peritonitis pressure increases the pain; the pain becomes more diffuse, the abdomen is not so rigid, there are no movements on respiration. Much caution must be observed, for many of these signs do occur with colic as well. Our diagnosis will be materially strengthened if we can obtain an account of sudden attacks of pain running in certain directions, lasting various times, and passing off with the same

rapidity. We must remember that sudden and griping pain also occurs in enteritis, in the various kinds of colitis, in malignant disease, in the abdominal form of influenza, and in some patients after the ingestion of ices.

Diarrhœa must be shortly discussed, for it may be so acute as to come under the term "acute abdominal condition." In adults the commonest causes of diarrhœa are purgatives, food, ptomain poisoning, entozoa, uræmia, malaria, enteric fever, cholera, prolapse, malignant disease, and alcohol. The diagnosis of these conditions should not be difficult. In children there are three forms of acute diarrhœa —1. Mild intestinal catarrh. 2. Acute enterocolitis. 3. Septic or choleraic diarrhœa.

In making a diagnosis as to the cause of this sign, we must not forget the possibility of pneumonia or the eruptive fevers, remembering that enteric is rare in early life, and if it does occur constipation is almost always present, whilst if blood-stained stools are passed, especially by children, the possibility of intussusception must not be forgotten.

(To be continued.)

Change of Address.

Dr. J. Dell Bridger, from Kei Road, Cape Colony, to 50, Dartmouth Road, Cricklewood, N.W.

Mr. E. Clayton, L.D.S. Eng., from 47, Devonshire Street, W., to 63, Wimpole Street, W. (Telephone 1456 Paddington.)

Mr. Graham Hunt, L.D.S. Eng., from Guy's Hospital, to Percy Lodge, Torquay.

Dr. E. C. B. Ibotson, from Cinderford, Gloucestershire, to 14, Grenfell Road, Hereford.

Mr. J. R. Palmer, L.D.S. Eng., from Guy's Hospital, to c/o Edward Little, L.D.S., 153, Dock Street, Newport, Monmouthshire.

Mr. I. S. Spain, L.D.S. Eng., from Guy's Hospital, to 34, Prince of Wales Road, Norwich.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Pass List.

UNIVERSITY OF CAMBRIDGE, June, 1908.—Degree of M.B. conferred: A. Sydney Morton Palmer, M.A. (Jesus). Third Examination for Medical and Surgical Degrees: Part I., Pharmacology and General Pathology: H. L. Attwater (Pembroke), K. T. Khong (John), C. Searle (Pembroke).

Appointments.

Civil.

RANKINE, J. L., M.R.C.S., L.R.C.P. Lond., has been appointed Medical Officer and Public Vaccinator of the High District, Longtown Union, Medical Officer to Post Office, etc.

STRANGE, E. W., M.B. Lond., has been appointed District Medical Officer of the Droitwich Union.

WALES, E. G., M.B. Cantab., M.R.C.S., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Downham Market District of the County of Norfolk.

Military.

Surgeon-General F. W. TREVOR, C.B., M.B., British Medical Service, has been appointed Principal Medical Officer to His Majesty's Forces in India.

Army Medical Reserve of Officers.—Surgeon-Captain R. H. LUCE, M.B., to be Surgeon-Major.

Surgeon-Captain H. J. HOLMAN, 1st Cinque Ports Volunteer Rifle Corps, resigns his commission.

Papers by Guy's Men.

The Milroy Lectures on Melitensis Septicæmia (Malta or Mediterranean Fever). By J. W. H. Eyre, M.D., M.S. Durh., D.P.H. Cantab. Lectures I., II., and III. (Illustrated.)—*The Lancet*, 13th, 20th, and 27th June, 1908.

General Hospitals and the Provident System. By E. Clifford Beale, M.B. Cantab., F.R.C.P. Lond.—*British Medical Journal*, 20th June, 1908.

The Future of the Voluntary Hospital and its Relation to a Reformed Poor-Law Medical Service. By Lauriston E. Shaw, M.D. Lond., F.R.C.P. Lond.—*British Medical Journal*, 20th June, 1908.

Some Lesions of the Spinal Cord produced by Experimental Caisson Disease. By A. E. Boycott, M.A., M.D. Oxon., and another.—*Journal of Pathology and Bacteriology* for April, 1908.

Extirpation of the Lacrymal Sac. By O. J. Currie, M.B. Lond. and Cape University, M.R.C.S. Eng.—*The Lancet*, 4th July, 1908.

African Tick Fever.—A Personal Experience. By Captain A. C. H. Gray, R.A.M.C.—*Journal of the Royal Army Medical Corps*, July, 1908.

The Climates Suitable for the Aged. By Sir Herman Weber, M.D., F.R.C.P. Lond.—*The Practitioner*, July, 1908.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated.*

The Biennial Dinner.

"Eheu! fugaces labuntur anni."

THIS highly successful gathering took place on Wednesday evening last in the Victoria Hall, at the Hotel Cecil, Mr. Symonds in the chair. Over three hundred and thirty guests participated in what was voted, on all sides, the most enjoyable evening of its kind yet spent. The arrangements, in the hands of Dr. Shaw, were admirable to a superlative degree, every detail being carried out without the slightest hitch. The work which the organisation of this festival entailed must have been enormous, and we cannot congratulate Dr. Shaw too much on the great success which his efforts met with. To Mrs. Shaw, who rendered him the greatest assistance, the thanks of all are due. This lady's ability, so well known in connection with the Guy's Association, was appreciated to the utmost; she has given much time to the assistance of Dr. Shaw, much of the detail being left to her. We trust that she realizes what a huge success the whole affair was, and that she feels that after-glow of satisfaction which successful efforts should meet with.

Shortly after 6.30 p.m. Guy's men of all years began to arrive at the famous Strand hotel. Venerable men of the entries of the middle of last century, middle-aged practitioners of many years' standing, men who were doing house appointments when some of us were struggling with the embryology of the amphioxus, up to those amongst us who still have places at the Residents' table, even to men who still have to face the ordeal of some hours' interrogation and expectancy at that pile on the Embankment where "fair hopes are dashed, etc." There was a constant stream into the huge reception room, Mr. Symonds welcoming all with a cheery word and handshake. What a gathering of medicos! what a réunion! Old friends, who for years have not met, would recognise one another—a hearty welcome, mutual inquiries, and a stream of reminiscences. One would hear, "Why, there is So-and-So, one of our entry, wasn't he?" "Hasn't he aged," or "How fit he is looking," and the merry group would be joined by another. More mutual inquiries; more reminiscences.

The range was extensive, from 1849 to 1908. Forms which, all too unfortunately, we see too little of at Guy's now—Mr. Bryant, Dr. Pye-Smith, Dr. Pavy, Dr. Savage Dr. Goodhart, Dr. Taylor, Dr. Brailey, Mr. Higgens, Dr. Galabin—were moving here and there, and being welcomed by their old friends and pupils. The réunion was at its height when stentorian tones brought the guests back to the more material side with a "Dinner is served, gentlemen."

One would have imagined that trying to find one's place and table would have been well-nigh impossible; but no, for the programme—a veritable work of art—contained a scheme wherein was shown the disposition of the tables. One had merely to look up the name in the index and note the number, which tallied with a certain table. Each table was arranged as much as possible in years of qualification, and each was headed by a vice-chairman. Of course, there followed a still further réunion. Old friends who had not met in the reception room found themselves neighbours at table, all due to that wizard, Dr. Shaw.

The menu was an excellent one; the service good. Full justice having been done, Mr. Symonds proposed the usual loyal toast. Speeches were barred, an arrangement which, on an occasion like this, was much appreciated, for these brief hours pass all too quickly when old friends meet. One face which many missed was that of Sir Samuel Wilks, and one and all were pleased to hear, from the Chairman, that he was progressing favourably after his operation, and gaining strength daily. The following telegram was sent, amidst much applause:—

"Three hundred old Guy's men send you cordial greetings and best wishes for complete recovery."

Mr. Fred Keel then entertained the company with a song, "The Little Red Fox," and Mr. Harrison Hill with an amusing sketch at the piano; his income-tax song and "Three Blind Mice" à la Chopin, Handel and Wagner, were greatly appreciated.

Mr. Cosmo Bonsor proposed the Chairman, a toast received with musical honours.

Mr. Symonds acknowledged his thanks. On the programme—the frontispiece of which, by the way, was engraved with an excellent photo of the esteemed Chairman—there had been printed the Chairman's greetings, which we here reproduce.

"It having been decided at a meeting of the Stewards to dispense with speeches to-night, I must, as your Chairman, in some other form welcome you all to this Biennial Dinner. Everyone recognizes the importance of these gatherings as a means of renewing old friendships, and of forming new ones amongst those whom we knew but slightly in our student days.

"It is a mutual pleasure again for former teachers and students to meet under the genial influence of a gathering like this, some to find a fellow student amongst the consulting staff, or still on the active staff. It must also be worth while for all to see and make the acquaintance of those entrusted with the great duty of maintaining the reputation of Guy's as a Hospital and Medical School. To-night you meet at one of the largest gatherings ever held—if, indeed, not the largest—a proof that there is no lack of enthusiasm amongst Guy's men, and that all appreciate the great value of these réunions. To-night, also, you meet when, for the first time for many years, it is possible to tell you that the Hospital stands *free from debt*—a position secured by the energy, the devotion and the influence of our Treasurer, Mr. Cosmo Bonsor.

"Let us gather year by year in yet increasing numbers, renew our old associations, and show what we believe—that Guy's stands second to none amongst the Medical Schools of this Metropolis."

Mr. Keel's next contribution, "A Hunting we will go," was supported by a good general chorus, and Mr. Harrison Hill's second sketch evoked general amusement. Dr. Shaw's and Mr. Eason's (who had charge of the musical programme) health was drunk to great applause.

The final toast, "Guy's," was received and drunk with great enthusiasm, and followed by "Auld Lang Syne."

Slowly, loth to part, the guests made their way out, after an evening which was unique in many ways, an evening which will linger in the minds of many, and make all look forward with great interest to the next happy occasion.

Dental News.

The retiring Dental House-Surgeons, Messrs. Graham Hunt, I. S. Spain, and F. Holcombe Fuller left the Hospital on July 1st on completion of their duties. Things have gone pleasantly and smoothly for all concerned during their term of office, and they have with them our best wishes for their future success.

The new appointments are as follows:—

Dental House-Surgeons.—Messrs. Grant Oliver, E. E. Soloman, and F. N. Doubleday.

Assistant Dental House-Surgeons.—Messrs. Lacey, Tibbalds, and Roberts.

At the Annual General Meeting of the Society Mr. Spiller was elected President of the Society for the Session 1908–09, and Mr. Bull, Hon. Sec.

On Thursday last Dr. Morton kindly gave a demonstration for Dental men on Radiography. In view of the constantly increasing importance of skiagrams in the diagnosis and treatment of certain dental conditions, and especially in orthodontia, it is hoped that Dr. Morton will be able to repeat his demonstration again next term.

Heartiest congratulations are due to Mr. Hodgson who won the Operative Dentistry Prize last week, and to Mr. Sheppard who gained a Certificate.

Congratulations are also due to Mr. Morgan who has been awarded the Dental Society's Prize for the best paper read before them during the Session 1907–08.

The Casual Communications Prize goes to our popular retiring secretary, Mr. R. M. King.

Reviews.

The price of books submitted for review should in every case be stated.

An Introduction to Dermatology. By Norman Walker, M.D., F.R.C.P. Fourth edition. (Messrs. William Green & Sons.) 9s. 6d. net.

The fourth edition of this truly excellent book is a still greater credit to its author. The simplicity of style—dogmatic at times—the practical utility, and the introduction of all the latest ideas in dermatological therapeutics, have been enhanced by the change in coloured illustrations. Coloured plates are a necessity in the early study of dermatology, and the student will find many of those in Dr. Walker's book veritable masterpieces. The print is large, the book is not cumbersome, and the ground covered sufficient for all purposes of general practice. We know of no other book on skin diseases which the student will find to answer his purpose so well.

Nerve Diseases. By L. A. Clutterbuck, M.A., M.R.C.P., etc. (The Scientific Press. Ltd.) 3s. net.

On the cover and in the prefatory note the author states that this book is for the use of students commencing Hospital Practice. It is meant to aid the student in obtaining a grasp of that complicated section of medicine, nervous diseases. As one would expect, the diseases dealt with are those which he is most likely to meet, and a classification based on the usual scheme is given. The diseases are dealt with in an elementary manner, certainly lucid, but we doubt whether the student who goes around with his physician will gain much from the volume. There is very little space devoted to treatment, so we must not cavil if we find many modern ideas excluded. We think that the ordinary text-book on medicine covers all the ground that the author has gone over, both as regards clinical points and general remarks, and that the student will find it unnecessary to add to his ever-increasing library.

Hygiene of the Lung. By Professor F. Leopold von Schrötter, Vienna University. (Reban, Ltd.) 2s. net.

This short work, translated by H. W. Armit, will be found very useful to the lay public. It describes the diseases of the lungs in simple easy language, so that non-professional readers can readily understand the principal predisposing and direct causes. There is also a considerable amount of good sound advice *re* prophylaxis and the attempted cure of diseased lungs which cannot fail to be of value. Dissemination of such knowledge is to be strongly advocated, and this little volume serves an excellent purpose.

Public Health Laboratory Work. By Henry Kenwood, M.B. (H. K. Lewis.) 10s. 6d. net.

This book has been largely re-written, and a considerable amount of new material added, especially in the matter of water, milk, and sewage analysis. This has been brought thoroughly up to date, the latest in every process, &c., being added and commented upon. The pages have been enlarged, also the type, making the book a most readable one. A section devoted to bacteriology, written by W. S. Savage, M.D., has been added, and is the most up-to-date public health bacteriology we have read. For a student of public health and as a companion in the laboratory, we know of no better book dealing with analysis. We cannot praise it too highly.

Hernia: its Causes and Treatment. By R. W. Murray, F.R.C.S. (J. & A. Churchill.) 4s. 6d. net.

In this most attractive little volume Mr. Murray makes out a very strong case for the saccular theory of hernia. Attacking the subject from the anatomical point of view, he shows that there is ample evidence from post-mortem findings to justify his theory of a pre-existent sac in all cases of hernia. So convinced is the author of the point, that he has treated his cases on this assumption, and his statistics show that ligature of the sac alone brings about a cure in all except old patients. There is a short account of the geographical distribution of hernia.

Preparation Received.

Glaxo (A Starchless Milk Food for Infants).

We have received from the Glaxo Company, 88, Gracechurch Street, E.C., a sample of their Milk-Food for Infants. It is a powder prepared under the most aseptic conditions from the milk of specially examined cows. Its chemical composition, according to our analysis, shows fats, 27·4; proteids, 22·2; sugar, 41·0; whilst the moisture and inorganic ash are 3·4 per cent. and 6·0 per cent. respectively. The fats are in the form of free fatty acids, and the proteids in such a condition that a fine granular and not a solid clot ensued on treatment with Rennet. The Proprietors claim that this enhances its digestive properties. Its bacteriological examination is certainly remarkable, only 200 organisms, and these non-pathogenic, per cubic centimetre at 22° C. It has been tried on the District and at the Surrey Dispensary, and the reports are satisfactory. Its relative sterility points to it being very useful in summer diarrhœa. The Glaxo Company will be pleased to forward samples and literature on written application.

NOTE.—We would like to remind those men who will soon be away on their long vacation that the GAZETTE will always welcome copy, telling of travels or adventures.

Sport.

Cricket.

GUY'S v. HAMPSTEAD.

Played at Hampstead on June 24th, when the Hospital lowered Hampstead's ground record for the first time this season.

HAMPSTEAD.

E. E. Barnett, c Charlton, b Kahlenberg	2
E. W. Sutton, b Charlton	8
H. G. Blomfield, c & b Kahlenberg	16
J. Crosdale, c Medlock, b Kahlenberg	57
E. W. H. Beaton, c Clapperton, b Kahlenberg	31
A. R. Trimer, c Miller, b Clapperton	41
L. Pavitt, c Munden, b Kahlenberg	10
Count Hollender, run out	0
H. S. Chappell, b Kahlenberg	3
J. V. Nimmo, b Kahlenberg	8
E. L. Marsden, not out	0
Extras	27
Total	203

GUY'S.

M. M. Munden, b Pavitt	23
C. H. Medlock, b Chappell	26
A. H. Birks, c Crosdale, b Trimer	44
R. Montgomery, not out	63
P. C. Charlton, lbw, b Marsden	8
W. C. Miller, b Marsden	13
S. W. Jamieson, b Pavitt	0
J. H. Clapperton, b Marsden	7
F. Kahlenberg, c Beaton, b Chappell	0
F. Tooth, b Trimer	20
L. D. Wright, b Marsden	0
Extras	24
Total	228

GUY'S v. GRANVILLE (LEE).

Played at Honor Oak Park on June 27th, and ended in a draw.

GUY'S.

M. M. Munden, b Johnston	18
C. H. Medlock, c Sandiford, b Derick	32
H. Lee, c Kendle, b Johnston	57
P. C. Charlton, b Sandiford	17
R. Montgomery, c Johnston, b Derick	75
A. H. Birks, c Sandiford, b Gale	64
W. T. Clarke, not out	33
F. Tooth, c Lowis, b Derick	0
W. C. Miller, not out	1
Extras	12
Total (for 7 wickets)	309

Innings declared closed.

F. Kahlenberg and J. H. Clapperton did not bat.

GRANVILLE.

J. S. Lelen, lbw, b Charlton	5
Major Lowis, b Tooth	40
V. B. Longworth, c Lee, b Kahlenberg	48
C. E. C. Kendle, b Kahlenberg	20
J. P. Clarkson, not out	61
A. S. Johnston, c Munden, b Tooth	1
P. P. Lincoln, not out	25
Extras	11
Total (for 5 wickets)	211

J. E. Lander, H. Sandiford, E. T. Gale, and W. E. Derick did not bat.

GUY'S v. LONDON.

CUP TIE.—SEMI-FINAL.

Played at Chiswick on June 29th, and ended in an easy win for Guy's by 200 runs. Guy's scoring was very consistent, everyone reaching double figures.

GUY'S.

M. M. Munden, c Hancock, b Clarke	25
C. H. Medlock, b Burgess	43
H. Lee, b Clarke	79
R. Montgomery, c Salt, b Burgess	13
P. C. Charlton, c Paget-Tomlinson, b Clarke	19
A. H. Birks, c Salt, b Leney	23
W. T. Clarke, b Carr	29
A. C. Hancock, c Owens, b Carr	22
J. H. Clapperton, c Leney, b Clarke	19
F. Kahlenberg, c Leney, b Owens	25
F. Tooth, not out	20
Extras	22
Total	339

LONDON.

E. L. Leney, c Charlton, b Kahlenberg	5
N. L. Clarke, run out	1
H. A. Hancock, b Charlton	13
R. Burgess, c Birks, b Clapperton	66
J. S. Jobson, b Charlton	1
H. F. G. Noyes, b Charlton	3
C. E. F. Salt, b Kahlenberg	15
T. H. Owens, b Tooth	0
E. Paget-Tomlinson, not out	33
C. Gibson, c Hancock, b Clapperton	0
W. G. Carr, run out	17
Extras	2
Total	156

GUY'S v. WANDERERS.

Played at Honor Oak Park on July 4th, and ended in an easy win for the Hospital.

GUY'S.

M. M. Munden, c & b Jephson	2
C. H. Medlock, c Damian, b Taylor	3
R. Montgomery, lbw, b Colman	34
A. H. Birks, c Kenward, b Damian	42
W. T. Clarke, c Colman, b Damian	13
W. C. Miller, st Behrend, b Jephson	11
A. C. Hancock, not out	37
J. H. Clapperton, b Damian	1
J. F. Young, c Behrend, b Damian	9
F. Kahlenberg, c Taylor, b Tolkein	27
P. Humm, c Ficher, b Tolkein	0
Extras	9
Total	188

WANDERERS.

S. Colman, lbw, b Young	16
Hon. S. R. Beresford, c Hancock, b Young	6
R. Kenward, b Young	5
E. H. Ficher, c Birks, b Kahlenberg	11
T. A. Darke, c Montgomery, b Kahlenberg	24
D. L. A. Jephson, c Montgomery, b Kahlenberg	2
J. H. A. Tolkein, c Munden, b Kahlenberg	4
J. E. S. Hadath, c & b Clapperton	14
N. A. Damian, c Clarke, b Clapperton	2
A. H. Behrend, c Montgomery, b Kahlenberg	0
O. Taylor, not out	0
Extras	8
Total	92

FINAL CUP TIE.

GUY'S v. ST. THOMAS'S

WILL BE PLAYED ON

MONDAY, TUESDAY AND WEDNESDAY, JULY 20th, 21st & 22nd.

Lawn Tennis.

CUP-TIES.

1ST VI. v. ST. THOMAS'S.

This match took place at Chiswick on Wednesday, June 24th, and resulted in a win for Guy's by 8 matches to 4; 3 being left unfinished. We led in the singles by 4 matches to 2, and won the doubles by the same margin. F. T. Cutler showed brilliant form in the singles, beating Dawes in 2 straight sets. Results :—

Singles.—F. T. Cutler beat H. E. T. Dawes, 6–4, 6–4; A. S. Roe lost to C. Gouldesbrough, 4–6, 2–6; H. Sharpe beat A. C. Gemmell, 5–7, 6–1, 6–4; H. Chapple beat A. J. Rae, 6–1, 2–6, 6–2; R. Curle lost to G. Brandon, 4–6, 4–6; M. M. Earle beat A. C. Pickett, 6–2, 7–5.

Doubles.—H. Chapple and H. Sharpe lost to H. E. T. Dawes and A. C. Gemmell, 6–3, 2–6, 4–6; beat C. Gouldesbrough and G. Brandon, 6–4, 6–3. F. T. Cutler and R. Curle beat C. Gouldesbrough and G. Brandon, 6–4, 6–2; beat A. J. Rae and A. C. Pickett, 6–3, 6–2. A. S. Roe and M. M. Earle beat A. J. Rae and A. C. Pickett, 6–0, 6–2.

1ST VI. v. KING'S.

SEMI-FINAL.

This match took place at Chiswick on Thursday, June 25th, and resulted in a win for Guy's by 8 matches to 1; 6 being left unfinished. We led in the singles 6 matches to nil, and won the doubles 2 matches to 1. H. Chapple and H. Sharpe lost to King's first pair, this being the only match we lost. Results :—

Singles.—F. T. Cutler beat A. H. Fyzee, 6–2, 7–5; A. S. Roe beat A. S. Gillett, 6–1, 6–0; H. Sharpe beat

D. Hamilton, 6–3, 6–2; H. Chapple beat H. W. Wiltshire, 6–0, 6–1; R. Curle beat D. H. Kanga, 8–6, 6–2; M. M. Earle beat W. P. Briscoe, 6–0, 7–5.

Doubles.—H. Chapple and H. Sharpe lost to A. S. Gillett and A. H. Fyzee, 3–6, 3–6; F. T. Cutler and R. Curle beat D. Hamilton and H. W. Wiltshire, 6–4; A. S. Roe and M. M. Earle beat W. T. Briscoe and D. H. Kanga, 6–2, 5–7, 6–2.

1ST VI. v. LONDON.

FINAL.

This match took place at Chiswick on Friday, June 26th, and resulted in a win for us by 8 matches to 1. We led in the singles by 5 matches to 1, and won the first round of the doubles by 3 matches to 0, thus winning the Cup, which we have not held for the last 15 years. Results:—

Singles.—F. T. Cutler beat L. Powell, 6–2, 5–7, 6–2; A. S. Roe beat S. G. Luxer, 7–5, 7–5; H. Sharpe lost to R. T. Vernon, 1–6, 4–6; H. Chapple beat H. McLean, 6–2, 6–1; R. Curle beat G. T. Shann, 6–3, 6–0; M. M. Earle beat G. L. Siddle, 6–0, 6–0.

Doubles.—H. Chapple and H. Sharpe beat S. G. Luxer and L. Powell, 6–2, 6–2; F. T. Cutler and R. Curle beat A. T. Vernon and H. McLean, 6–0, 6–2; A. S. Roe and M. M. Earle beat G. T. Shann and G. L. Siddle, 6–2, 3–6, 6–0.

1ST VI. v. LYONSDOWN.

This match took place at New Barnet on Wednesday, July 1st, and resulted in a win for us by 5 matches to 4.

1ST VI. v. WEST DULWICH.

This match took place at Honor Oak Park on Saturday, July 4th, and resulted in a win for West Dulwich.

Swimming Club.

Team swimming race (four a side). This event should have been decided at St. George's Baths, Westminster, on Thursday, June 25th, Westminster Hospital scratched owing to their inability to raise a team.

INTER-HOSPITAL POLO CUP, FIRST ROUND.

GUY'S (HOLDERS) v. ST. THOMAS'.

This match was played at Southwark Baths on Friday, June 26th. Guy's were easily the better team and outplayed their opponents at all points, eventually running out easy winners by eleven goals to nil. The following were the scores:—

Glover 3, Ball 2, Moberley 4, Clarke and Pritchard 1 each.

REMARKS.—The team did not play up to its usual form. This, no doubt, was due to the fact that they soon found the measure of their opponents. Passing was poor, and too great a tendency to shoot from a far distance instead of passing to a man quite unmarked and in a favourable position. A pleasing feature was the large number of men who turned up to watch the match. It is to be hoped even more will be present at the next round. Teams:—

GUY'S.—H. N. Eccles, goal; G. B. Pritchard, G. Rice, backs; W. Clarke (Capt.), half-back; M. E. Ball, H. H. Glover, A. Moberley, forwards.

ST. THOMAS'S.—A. R. Hargreaves, goal; A. R. Parkinson, R. S. Overton, backs; E. W. Witney, half-back; R. Reece, E. L. Rhodes, M. Littlewood, forwards.

Referee.—Mr. P. Seymour-Price.

Timekeeper.—Mr. S. McK. Saunders.

Births.

BUTLER.—On June 29th, at 280, Goldhawk Road, W., the wife of J. A. Butler, M.D., B.S. Lond., of a son.

LAVERS.—On June 17th, at Bath, the wife of Norman Lavers, M.D., of a son (Geoffrey Le Mesurier).

ROBERTS.—On 15th June, at 2, Tubs Hill, Sevenoaks, the wife of Richard Roberts, L.D.S., of a son.

Marriages.

PRICE—JARMAIN.—On June 27th, at the Parish Church, Beckenham, by the Rev. F. E. Franks, of St. Thomas, Clapton, assisted by the Rev. G. O. F. Griffith, Vicar of St. Barnabas, Beckenham, Charles Edwin Price, M.R.C.S. Eng., L.R.C.P. Lond., The Croft, Orpington, to Muriel Frances, only child of William Arthur Jarmain, of Clovelly, Shortlands.

RANKINE—ALEXANDER.—On June 16th, at Carlisle, John Lawson Rankine, M.R.C.S., L.R.C.P. Lond., eldest son of Adam Rankine, late of Education Department, to Jessie Blair Alexander, daughter of the late James Alexander.

TICEHURST—TAYLOR.—On the 27th June, at St. James' Church, Weybridge, by the Rev. E. G. Swain, Vicar of Stanground, Peterborough, assisted by the Rev. Spencer R. A. Buller, Rector of the Parish, and the Rev. C. R. Taylor, Gerald Augustus Ticehurst, M.A., M.B. Cantab., of 54, London Road, St. Leonards-on-Sea, second son of Augustus Rowland Ticehurst, J.P., M.R.C.S., of Huntbourne, High Halden, Kent, to Etta, second daughter of William Bramley Taylor, J.P., M.R.C.S., of the Birches, Weybridge Common, late of Denmark Hill.

Deaths.

ASHBY.—On July 5th, at 3, Lancaster Road, Didsbury, Manchester, Henry Ashby, M.D. Lond., aged 62 years.

BUTLER.—On July 3rd, at 280, Goldhawk Road, W., James Swift Butler, the only child of Dr. and Mrs. J. A. Butler, aged five days.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

MR. GOLDING-BIRD, our Senior Surgeon, took his leave of us last Tuesday, when, on the occasion of his last round, men of all years, past and present, turned up to pay their homage to one who has ever been their much-respected and ever-esteemed teacher. For us to dilate here, to any great extent, on the characteristics which have always made Mr. Golding-Bird—or may we say G.-B., it comes so naturally?—one of the most popular of our surgeons of recent times, would savour of banality. The ever-ready sympathy, the never-failing sense of humour—that sovereign trait—the geniality, and many other qualities which endeared him to all as a teacher and a man, are too well known. His Tuesday afternoons were a feature of our hospital life, and we doubt not that men in distant climes reading these lines will have brought back to them many a memory, and many a story, maybe, which will cause them to pause, and will carry them back to their last year or so as students. There is something exceedingly pathetic about a departure of one who for so long has been an entity of our daily hospital life; all of those who, after a brief five or seven years have felt the pang of the final farewell to this dear old Hospital will realize what we mean. The *genius loci* is a power which enslaves us entirely. Ask yourselves, you men who are still here, how will you like the final break? How, then, must it feel to sever connection—for, after all, the Consultant Staff is almost a thing apart—after a period of 40 years.

HE entered as a student in 1868. Showing much promise, he took his qualification, L.R.C.P., in 1872. The following year, he took his M.B. London, with honours, and the Gold Medal in Medical Jurisprudence. He was appointed House-Surgeon, and after his term of office was ended he received a House Physicianship. There was, at this time, a hint of the possibility of his going on to the Staff, and, feeling that he had a "penchant" for surgery, he resigned his post as House-Physician and decided to do his F.R.C.S. He went to Paris in the autumn of 1873, and, whilst doing a course of anatomy, attended one or other of the surgical cliniques. The next year he returned, and passed both the

Primary and Fina F.R.C.S. examinations together. He then became attached to the Staff, and from that date, the winter of 1874, he has given much of his labour to the hospital.

We will not give a list of the many papers he has contributed to medical literature. His association with the introduction of the Hodgen splint into England, his sling for flat-foot, and his paper on keloids, published in the Reports, are, perhaps, three of the best-known of his accomplishments. His hobby—and notes of this character are seldom complete without a mention of this kind—is clocks. Ever of a mechanical turn of mind, he delighted to make himself proficient in all that pertained to time-pieces. The "send off" which Mr. Golding-Bird received on Tuesday last gave him, we trust, some idea of his popularity. It was sincere in every respect, and we hope that for many years to come we shall see him very frequently amongst us.

On another page will be found an appreciation written by an aforetime member of the G.-B. firm. Its sentiment, we are certain, will find an echo in the thoughts of all who have ever had the privilege of working under Mr. Golding-Bird. The inset photograph brings out many of his characteristics, and is indeed an excellent portrait. Our artist's drawing, also an inset, will be appreciated by many, and we cannot refrain from congratulating R. M. W. here on his excellent piece of work.

We have many times been asked where one can find some account of Bier's congestion method of treatment. Those who are anxious to try, what on the Continent has been adopted as a general routine, and in England is being used more extensively every day, will find an interesting paper in the *B. M. J.* of July 18th, by Mr. H. Waterhouse, F.R.C.S.

An interesting feature of the Irish village, at the Franco-British, is the Tuberculosis Exhibition on view in the Village Hall. This is a reproduction, on a small scale, of the Tuberculosis Exhibition, now on tour in Ireland, promoted by Her Excellency, Lady Aberdeen, and includes the following four sections:—Pathological, Veterinary, Appliance, and Statistical. The Pathological section consists of specimens of human lungs and intestines in various stages of tubercular disease. The Veterinary section comprises examples of tuberculosis in the lower animals, including diseased and healthy bones for contrast. The Appliance section includes sputum flasks, tissue-paper handkerchiefs, cheap spittoons from cardboard and peat, milk sterilizers, and appliances for the preparation of food for invalids and infants, simple open-air shelters, sun-boxes, and photographs of various Irish sanatoria, etc. The Statistical section consists of diagrams and maps showing the appalling death-rate from tuberculosis in Ireland. Copies of literature distributed through the medium of the Tuberculosis Exhibition in Ireland are displayed on a large reading-desk. This literature covers every aspect of tuberculosis; the causation, prevention and treatment, including, as it does, copies of lectures delivered by the Registrar-General of Ireland, Sir Robert Matheson, LL.D., Professor Osler, M.D., F.R.S., Professor McWeeny, M.D., and Sir John Byers, M.A., M.D., together with simple directions as to ventilation, cleanliness, food and milk supply.

"Contrast" bedrooms, as shown by the Exhibition on tour, are also reproduced here, and form a very valuable object-lesson. On the one side we see thorough ventilation, brightness, cleanliness, and simplicity; on the other, darkness, dust, heavy curtains, ragged carpet, tightly closed windows, in short, every accessory for the development and spreading of disease.

On July 15th, Lady Aberdeen opened the Sanatorium. It is well worth the attention of the visitor, as, in fact, are all of the features in this very interesting and complete model village. A point to bear in mind is, that all profits derived from the "gate," and also sales in the village, go to the aid of the crusade of Lady Aberdeen against tuberculosis in Ireland.

It was with regret that we chronicled the death of Dr. Henry Ashby in our last number, and the long appreciative obituary notices which have appeared in many journals—both lay and medical—give some measure of the universal respect in which the deceased was held. He entered Guy's in 1868, and after a brilliant career carried off the Treasurer's Gold Medal for Medicine in 1873, qualifying by taking the L.R.C.P. the same year. In 1874 he took his M.B. (Lond.), and held the posts of House-Physician and Resident Obstetric. In 1878 he took his M.D. (Lond.), carrying off one of the medals. For a brief period he was an Assistant in the Physiology Department; leaving this post he moved to Liverpool, being appointed Demonstrator of Anatomy to the Liverpool School.

He later became attached to the Hospital for Children, Manchester, better known, maybe, as the Pendlebury Hospital, and henceforward he devoted his career to ailments of children. He was interested in them in every aspect, moral, physical and hygienic. His opinion carried great weight, and was an asset which Manchester valued very highly indeed. He was elected an F.R.C.P. in 1890. His contributions to medical literature were numerous; amongst them may be quoted his Notes on Physiology, which ran to many editions, and his Diseases of Children, written in conjunction with Professor G. A. Wright, which is a classic. His personality was one which endeared him to all his friends, and in him Manchester has lost a very valuable and highly-respected citizen. We extend to his widow and family our most sincere condolence.

The Works Department is already at work on the improvements in the Anatomy Department. The unsightly chimney—sometimes known by the appellation of Hancock's delight—which has been the subject of many derogatory remarks, spoiling, as it does, the effect of the nurses' Roman colonnade, is slowly, but surely, being demolished. Hancock's room is to be finished with tiles throughout. The rooms on the first storey are to be knocked into one large room, and a good head-light is to be provided. Those who have done their operative surgery will appreciate what this improvement will mean, for, apart from the overcrowding, the inconvenience from poor lighting was considerable. A lift is to be fitted, which will extend from the basement below the new colonnade to the new operative surgery class-room, so that, when the work is completed, this portion of the school will be brought well into line with all that is modern.

It is with regret that we chronicle the approaching departure of Miss C. M. Crampton, Sister Surgery. She is leaving us owing to the illness of her father. We trust that, under her experienced care, he will make excellent progress and a complete recovery.

Sister Surgery entered the hospital in October, 1900. From September, 1904, to May, 1905, she was attached to the Institute, returning in April, 1905, to take up the duties of Night Sister. She has had charge of the Front Surgery since June, 1905, and how capably she has carried out her duties everyone who has had the pleasure of working with her can testify. Her fund of sympathy, evenness of

temper, and extraordinary tact made her the ideal person for the position. She exercised over the crowd—so varied in its composition, and at times so troublesome—which patronises the Front, a remarkable power. From the tiniest shrieking tot to the Borough bully her power extended. The sight of Sister dealing with the "gentleman" who was going to "lay out every blooming doctor in the place," and was about to give a demonstration of his bibulous pugnacity, was a sight for the gods. A few words in her quiet manner, and his turbulence would give way to a demeanour which would have done credit to a church mouse. She will be sadly missed by us all, and we wish her every happiness.

SIR ARTHUR RÜCKER'S successor as Principal of London University is Prof. Henry Alexander Miers, Fellow of Magdalen College, Oxford, and Waynflete Professor of Mineralogy in that University. His appointment dates from October 1st, when Sir Arthur will deliver up the robes of office.

WE have never before, we believe, been the victors in the Inter-Hospital Team Swimming Race; Polo has always been our forte. This year, however, thanks to the fine efforts of Messrs. Glover, Moberley, Pritchard and C. D. Roberts, we were successful. May the Trophy find the Smoking-room much to its liking, and be content to rest there many a day!

The Final Cricket Cup Tie resulted in a win for St. Thomas's. Our men lost their accustomed dash, and the soft wicket was not to their liking. Assuredly our chances seemed most cheery this year, for the record of the team was excellent. Out of 22 matches played they had won 15, lost 4, and drawn 3. The averages are well worth attention; A. H. Birks was top of the batting list with 41·91, and P. C. Charlton headed the bowling with 12. We congratulate the XI. on their season, and regret that its ending was not a more felicitous one. Full details on page 300.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. S. H. Browning (Dr. Hale White); H. Lee (Dr. Pitt).

Ophthalmic Dressers.—(August 1st) Messrs. H. I. Janmahomed, W. E. Wallis (Mr. Eason); T. F. Brown, D. C. Druit (Mr. Ormond); (September 16th) J. Walker, E. R. Stone (Mr. Eason); A. E. Lees, H. W. Heasman (Mr. Ormond).

Surgeons' Dressers.—Messrs. R. C. H. Francis, H. L. Attwater, F. D. Saner, W. S. Kidd, W. E. Williams (Mr. Symonds); N. A. D. Sharp, H. Steinbach, A. H. G. Burton, F. C. Endean, H. Platts (Mr. Lane); J. L. Johnston, A. L. Fitzmaurice, G. H. Peall, C. C. Tudge, W. H. Catto (Mr. Dunn); E. L. Elliott, W. Ledlie, D. A. Mitchell, C. Weller, W. L. Hibbert (Sir A. Fripp).

Obstetric Dressers.—(September and October) Messrs. C. A. Wood, C. F. Searle (Dr. Horrocks); C. C. Holman (Mr. Targett).

Externs.—Messrs. C. H. Crump, J. L. Atkinson, C. A. Wood, R. A. Rankine, P. C. Field (August); L. Bromley, V. T. P. Webster, F. Kahlenberg, A. A. Greenwood, G. F. Haycraft (September); Q. H. Richardson, E. Duvivier, C. G. Sprague, R. G, Oram (October).

Civil.

BEAUMONT, A. R., M.R.C.S., L.R.C.P. Lond., has been appointed Resident Assistant Anæsthetist at St. Mary's Hospital.

GREEN, A., M.B. Lond., L.R.C.P. Lond., M.R.C.S., has been appointed Certifying Surgeon under the Factory and Workshop Act, for the Chesterfield District of the County of Derby.

MOYLE, R., L.R.C.P. Lond., M.R.C.S., has been appointed District Medical Officer to the Chepstow Union.

SHORLAND, E. TREVOR, L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of Health by the Westbury (Wilts) Urban Council, and Medical Officer of Health by the Westbury (Wilts) Rural District Council.

STEVENS, THOS. GEORGE, M.D., B.S. Lond., M.R.C.P. Lond., F.R.C.S. Eng., has been appointed Physician to Out-patients at Queen Charlotte's Lying-in-Hospital.

WEDD, B., M.D. Lond., has been appointed Bacteriologist to the Royal London Ophthalmic Hospital.

Pass List.

UNIVERSITY OF OXFORD.—Second M.B. Examination: G. H. Hunt, Christ Church.

Tempora Mutantur.

"COMING round with 'G.-B.?'" is a question so familiar, so essentially a part of the senior men's weekly conversation at Guy's, that it seems impossible to realize that one will hear it no more. To generations of house-surgeons, dressers and ward clerks, and to countless camp-followers from general practice, medical school and dental department, the first question heard on arrival at hospital on Tuesdays has been, "Coming round with "G.-B.?"

And on Tuesday last it was heard so many times, and at so many places, as to eclipse any other single occasion in the last thirty years. The same words as ever, perhaps, probably, asked a little more slowly, a little less casually, but with no qualifying phrase. Who could say, "Coming round with 'G.-B.' for the last time?"

Of course, far more men than were to be seen in Luke last Tuesday have been round with "G.-B." for the last time. But in their case, mingled with the sorrow of leaving the hospital, there has been the joy of passing in surgery, the enthusiasm and excitement of going out to practise. They came whilst "G.-B." was going round, they left him still going round; it never occurred to them that some day the surgical event of the week at Guy's must cease for ever. To us it was left to see the last round, to hear the last few words of practical advice, and to realise that next Tuesday will lack its customary feature of hospital life.

There was a big crowd in the colonnade soon after half-past one on Tuesday, when, amongst the usual following, were to be found members of all the other firms, silk-hatted practitioners, men on the junior staff, and more than one or two surgeons and physicians to the hospital. The murmur of conversation was continual, and was all centred on the event of the day. Men realised at last that it had come—the thing they had been regarding for months as a sort of far-off occasion which was somewhere in the dim future. No one had considered till Tuesday what it really meant, what Guy's really is going to lose, and before sufficient time had elapsed to think calmly of it, he is here; he is walking up the steps; his name appears on the board, where, alas! it will never be seen again, and the round has commenced.

Nobody except the house-surgeon has as yet thought of the cases, but within a very few minutes we are gathered round a man with a swollen jaw, listening to the voice we all know so well, speaking the words of wisdom which have helped so many men to add the letters M.R.C.S. to their names.

It is a case of actinomycosis, and "G.-B." is quickly engaged in a miniature clinical lecture on the subject. Diagnosis, treatment, and prognosis are fully dealt with; ætiology is touched upon, and an interesting note added to it. "I have seen many cases of actinomycosis in my life," says "G.-B.," "but never have come across one in which the patient in his daily work came in contact with grain." And this case is true to tradition; the patient is a sweet-jelly maker.

Then we are shown a case of tuberculous wrist which has been operated on. "G.-B." discusses the question of operation, referring to the work of Stuttgart of Copenhagen, whose methods he has adopted in this case with excellent result.

In Charity, where we go next, an even better result of the same treatment is seen: the case of a young girl who, after excision of her carpus, has a most useful hand.

But there is even better to follow; the best case of the day is that of a child who, following an attack of scarlet fever, was affected with almost absolute inability to swallow; and we listen with interest to the account of a case the like of which even "G.-B." has not had in his wards before.

After inspection of a parenchymatous thyroid enlargement, we descend to Cornelius, and are shown an old fractured femur, which has been treated by extension on a Hodgen with an excellent result. Humorously explaining that half an hour has to be spent before returning to Luke, "G.-B." launches out into a description of the history and value of the famous splint. He describes the cases to which the use of a Hodgen is limited, and then proceeds to enter thoroughly into the mechanics of the famous splint. A more complete and exhaustive bedside lecture we have never heard. Each point follows on from the last with perfect smoothness; the easy and obvious is passed over quickly, the rough and difficult is dwelt upon and emphasized with some witty recollection of the teacher's. "G.-B." is at his very best.

During this demonstration, Mr. Clement Lucas enters the ward, and, after listening for some minutes, departs with a friendly wave of the hand to his old co-worker and new co-member of the Consulting Staff.

And now the last round is over, the last word of surgical advice given; and, now over eighty in number, we return to Luke for the final good-bye.

Here we find Mrs. Golding-Bird, who is immediately presented with a bouquet by Jimmy, the youthful occupant of the cot, who, mounted on his crutches, wears a smile of immense pride, and will never forget this great day.

Passing up the ward, "G.-B." talks about tea, but no one seems to heed him. We have come to say good-bye, to listen to a final speech from our favourite lecturer, and tea is not to be thought of till the last word has been said.

Mr. Norman Flower, "G.-B.'s" last house-surgeon, with a few well-chosen words, presents Mr. and Mrs. Golding-Bird with a silver salver, bearing the following inscription, surmounted by the crest of the Hospital:

To C. H. GOLDING-BIRD, Esq., F.R.C.S.
In grateful appreciation of many kindnesses.
From old House-Surgeons and Dressers.

21st July, 1908.

At the same time is also presented "G.-B.'s" last take-in card, the work of Mr. R. M. Wingent, which is greatly admired, and necessitates a hearty hand-shake with its blushing artist, who has exercised his ingenuity and skill to their utmost.

Now comes the final speech, all too short; a speech characteristic of "G.-B." His rare gift of humour, which he cannot suppress; his power of touching so lightly from point to point; his unhesitating choice of the suitable word and phrase, are all as marked as ever. He addresses his audience as "Friends and Guy's men all," and tells them that though he is reluctant to leave the scene of his life's work, yet he feels that he would rather spend the winter free from the constant calls and demands to which an active Hospital Surgeon must be subject.

He has spent his hospital career at a time when surgery has undergone a perfect revolution. When he first entered the hospital, surgery was no more advanced than it was a hundred years previously. Water dressings were used, with occasionally a little nitric acid to tickle up the granulations. Linseed poultices were frequently employed, and he does not suppose that there is now a nurse in the hospital who has been taught how to make one. Oh, yes! they use them on the medical side now. (Laughter.)

He has seen other changes—in the use of the microscope, for instance. When he first came to Guy's there was only one microscope in the place, screwed down to a bench in the clinicals' room, which was used for all microscopic work. Later, Mr. Hilton started a pathology class, and six microscopes were added—great tall things, to look down which one had to climb up a ladder. Section cutting, too, has altered since those days, when one cut a wedge-shaped section with a razor, and had to look through the thin end of the wedge. (Laughter.)

Of all the people who were at Guy's when he arrived, forty years and six months ago, there are two left, Mr. Williams (of the counting-house), who is present in the ward now, and Mr. Monk, of the splint room.

And, before he closes, he must refer to another change—that in the nursing staff. He solemnly assures us he remembers Mrs. Gamp herself, and he knows he will offend nobody when he tells the story of a cold winter morning when, in the accident ward, no sober member of the night staff was to be found. This, he thinks, is the most charming change of all.

"And I do truly thank you, on Mrs. Golding-Bird's behalf and my own, for all your great kindness to me to-day, and this is a day I shall remember for the rest of my life. Thank you, all, and God bless you!"

He turns away, and wipes his pince-nez before returning them to their case. There is silence for a moment, and then a cheery voice invites us to take tea. The tension is ended, the last word is said, and we give up ourselves to that cheering and clapping which is the only relief, the only possible manner of combining praise and sympathy on such occasions as this.

After tea there is a large gathering on the colonnade steps as "G.-B." and Mrs. Golding-Bird pass out to their carriage. Mr. Flower calls for three cheers, which are lustily given, and cheer after cheer follows as they drive away until, with a final wave to the men on the steps, and the nurses and patients on Luke balcony, the carriage passes along St. Thomas's Street out of sight.

The crowd disperses slowly, the familiar name on the board is turned out of sight, and the last round is over. We can all realise what we have lost, we who have known and loved "G.-B." for five years. Do we realise what he loses, who has known Guy's for over forty? True, a place on the Consulting Staff is the highest honour Guy's can give her sons; but crowded lecture theatres and keen bedside discussions have come to an end, and must leave a blank for ever in the life of one of the most fluent speakers and merriest fellows Guy's has ever known.

M. E. B.

Diagnosis of Acute Abdominal Conditions

Treasurer's Prize Essay, Physical Society, 1908.

By R. G. CHASE, M.B., B.C., M.R.C.S., L.R.C.P.

(*Continued.*)

We now come to one of the commonest acute abdominal conditions, that is, intestinal obstruction. Has the patient whom we are called to see become obstructed, is a question which we may frequently have to decide. There are four great symptoms which we must enlarge upon, namely, pain, vomiting, collapse, and constipation. The pain may either come on suddenly with no warning, be very severe and continue without remission, or it may come on in fits and starts, and be colicy in character; or the pain may be due to, and therefore similar in character to, the pain of peritonitis. The vomiting may occur half an hour after the pain, or it may be delayed twelve hours. It is continuous, becoming worse and worse, and is usually intestinal from two to seven days from the onset. It is first of all gastric in character, then bilious, and lastly intestinal in character; and vomit being in the nature of a rushing stream while it lasts. Collapse is well marked in a few hours; the patient is pale, cold, and perspiring. The pulse is feeble; it may be slow at first, but later becomes very rapid. There is a dreadful thirst. Constipation is absolute; an enema will produce no result. The result of a second enema is either retained, or else it flows back with no force. No flatus is passed. There are said to be three exceptions to this:—In intussusception the tenesmus will sometimes produce a result. In volvulus of the sigmoid, contents sometimes pass. There is the diarrhœa associated with strangulation. On these four signs one may safely make a general diagnosis of intestinal obstruction.

Acute intestinal obstruction is due to:—Intussusception, bands, volvulus, gall-stones, internal hernia, external hernia.

The chronic forms which terminate acutely are due to:—Inpaction of a foreign body; bending, kinking, volvulus above a stenosis; acute paralysis of the gut. It is often impossible to differentiate these conditions. In a baby, total obstruction from birth is probably due to some congenital malformation: either a breach of continuity, or a septum, or a stricture, or even congenital ideopathic dilation of the colon, with absence of nervous reflex. In a child from one to two years old the probability is that obstruction is due to an intussusception, especially if the child is a male. In early adult life the commonest cause is hernia, whilst in large fat women about sixty years old an impacted gall-stone is a frequent cause.

Acute cases are not very distended; if it does occur, probably the obstruction is in the region of the lower colon. Distension, however, rapidly takes place in volvulus of the sigmoid. When strangulation occurs there is not much distension until peritonitis supervening paralyses the gut.

Tumours are felt in many cases of obstruction. In intussusception, the tumour can often be felt if the patient is made to sit up so that the lump gravitates downwards on to the examining finger in the rectum. H. L. Barnard says that a tumour can be felt in three-quarters of the cases of intussusception when examined under an anæsthetic. It is necessary to palpate the abdomen, and also examine per rectum and per vagina to feel these tumours. They may be:—pregnant uterus, fibroids, cyst or tumour of the ovary, sarcoma or carcinoma of the prostate, pelvic abscess, retroperitoneal sarcoma, renal tumours, cysts and abscesses. Hydatids, and even gall-stones, have been palpated at the ileo cæcal valve. When coils are seen contracting through the abdominal wall, it is important to remember that peristalsis of the stomach goes from left to right; whilst the peristalsis of the transverse colon proceeds from right to left; thus the organs can be distinguished by the direction of the peristaltic wave. An instrument that has come into more extensive use recently in the diagnosis of diseases of the lower bowel is the sigmoidscope. With this instrument the cause of the trouble can frequently be seen, whether it be a Murphy's button, an enterolith, fæcal masses, or large gall-stones.

Ballooning of the rectum occurs in cases in which there is a growth in the large bowel lower down, also in cases of peritonitis; and it has been described in acute colitis. Unfortunately, from the diagnosis point of view, we have to distinguish intestinal obstruction from many conditions which we will now proceed to consider in turn.

Any violent stimulation of the abdominal sympathetic nerves will produce pain, vomiting, collapse, and distension. The cause may be:—a renal calculus passing along the ureter; the passage of a biliary calculus; acute infection of the testis or ovary, etc.; torson.

However, to come to more direct troubles from a general survey of the cause of the condition, we must first of all exclude all external hernias. Of course, we shall look for the strangulated, inguinal, femoral, and umbilical; but we may as well include in our list, obturator, lumbar, and sciatica for the sake of completeness. These will all be very tender, except in very old people or very collapsed patients. These hernias will all give the general as well as local signs of strangulated hernia. Perhaps, however, the hernia will only be incarcerated, in which case there will not be so much pain: on the other hand, the tender lump may be only fæcal accumulation. If so, a soap and turpentine enema should relieve the symptoms and remove the lump.

We have noticed previously the similarity of acute peritonitis to intestinal obstruction. There is no absolute distinguishing sign. The vomiting is not intestinal in character with peritonitis so frequently as in obstruction, and the temperature is more frequently raised in the former disease. But cases are not uncommon of general suppurative peritonitis, in which the temperature is subnormal, and the pulse 80 or 90, and good volume.

It is useful to remember that the two often co-exist, for if strangulation of the intestine is present, peritonitis occurs after the fourth day. The tenderness of peritonitis is much more marked than that of obstruction.

In children, from about the age of three to ten years, we may mix up tubercular peritonitis with intestinal obstruction, the diagnosis usually being intussusception. The trouble may be due to the rupture of a caseous gland. The child will complain of severe abdominal pain, of sudden onset, and there will be constant vomiting and constipation, not relieved by ordinary purgatives or enemas. The temperature will be about 100, the tongue moist and creamy, and the pulse good. The abdomen will be tumid and slightly distended; it is not tender. Peristaltic contractions can be heard with a stethoscope, and a turpentine enema usually acts. Tubercular peritonitis may produce obstruction by bands, so that here again the two conditions may co-exist.

We will now try to separate those conditions which simulate intestinal obstruction by their stimulus to the sympathetic nervous system.

Renal Colic, besides exhibiting the signs and symptoms already discussed, common to all colic, will probably cause hæmaturia, which cannot be accounted for by any other lesion, such as infective endocarditis.

Biliary Colic, too, will simulate colic in general, but, in addition, the distribution of the pain downwards, inwards, and backwards in the lower region is characteristic. We shall be unlucky if there is no history of previous attacks. Jaundice will come on later. The difficulty here is to make the diagnosis in the first twenty-four hours.

Torsion of the testis will not lead to trouble in diagnosis if we examine the scrotum. The absence of one testicle from the scrotum or inguinal canal would be suspicious with sudden onset of symptoms.

Torsion of the ovary, which would certainly be enlarged, will be distinguished from obstruction by the history probably obtainable of an increasing size of the abdomen, and by the palpation of the tumour either abdominally, or per rectum, or per vagina.

In all these sympathetic cases a turpentine enema will cause flatus to pass. If flatus does pass, then the patient is not obstructed. To be quite sure this sign should occur with the second turpentine and soap enema.

With acute pancreatitis we get a sympathetic stimulation due to hæmorrhage into the mesentery together with a destructive fat necrosis in between the layers of the mesentery. Many of these attacks are apyrexial. The irritability of the ganglia produces severe pain, collapse, vomiting, and small feeble pulse. The pulse is very weak compared to other symptoms. The distended gut is due to sympathetic irritability inhibiting the movements of the intestine, and so producing constipation. We may get a similar sympathetic stimulation when acute inflammation occurs of either glands or hydatids, or when sudden hæmorrhage takes place into them.

We now come to a more important group from which we must distinguish obstruction, namely, gastro-intestinal irritation, whether due to arsenic or other poisons or to epidemics of cholera, enteric or colitis.

Acute strangulation is mistaken at times for poisoning, especially by arsenic, when there are suggestive circumstances.

Acute obstruction is often diagnosed as cholera when there are epidemics about the locality, more especially so when associated with anuria and early death. The diagnosis is not so difficult when diarrhœa is present, for this is very rare with obstruction. In a recent typhoid epidemic the signs and symptoms were often a very acute onset, profuse vomiting with severe colic and constipation. These were frequently diagnosed as acute appendicitis, and one patient was actually explored for intestinal obstruction.

Simple colic in children is often confounded with acute obstruction; but here the vomit is not intestinal in character, nor is the constipation absolute.

The separation of intussusception and colitis will come later.

Lead colic should give no trouble if it is thought of as a possibility for a mistake.

Uræmia may simulate intestinal obstruction to a marked degree. We must beware here, lest we too readily explain anuria by the frequency of the patient's vomit. A careful examination of the urine should separate the two very easily. If necessary, a catheter specimen must be obtained.

Tabes Dorsalis and other abdominal neuroses simulate this trouble by the profuse vomiting, complete constipation, and severe attacks of abdominal pain. We must look for other constitutional signs.

If we can discover a cause for either an embolus or a thrombosis in our patient, we should remember that if either of these events takes place in the mesenteric vessels a condition similar to intestinal obstruction occurs.

Having made a diagnosis of acute intestinal obstruction, we will now try to separate the various causes of this trouble, and we will consider them under five headings—those causes within the gut, those causes in the wall of the gut, those causes outside the gut, intussusception, and volvulus.

Beginning with those causes *inside the gut*, those which result in acute obstruction are very rare. They are, firstly, *foreign bodies* swallowed, or placed inside the intestinal canal surgically, such as a Murphy's button. Secondly, *concretions*, calculi, enteroliths. All are very rare conditions. Thirdly, *a fæcal mass*. This is hardly likely to cause acute obstruction without much previous trouble. Fourthly, a *gall-stone*. Here a large stone may pass into the duodenum by ulceration of the intervening walls, and cause obstruction of the duodenum by its size. Obstruction may also occur in patients with gall-stones, from stenosis caused by adhesions around the gall bladder. The patient in this case is likely to be elderly and fat, with a history of previous biliary trouble.

Next we must consider those causes of acute obstruction due to defects *in the gut wall*. The commonest of these troubles is *carcinoma coli*. In these cases there is usually a long history of previous trouble with the bowels, which suddenly become worse. A tumour is palpable in 40 per cent. of these cases. We must also remember tumours of other parts may invade the gut wall, and so produce obstruction. The next commonest defect of the gut wall which will produce obstruction is cicatrization, probably due to ulceration. We must, therefore, endeavour to find any sign or symptom of previous ulceration and its cause. The commonest of these ulcerations is probably tubercular, whilst the commonest cause of cicatrizing obstruction is probably traumatic, following either an abdominal injury, such as a cart wheel passing over the abdomen, or the insertion of a button with its subsequent cicatrix. Congenital stricture does occur and give rise to acute obstruction.

Those causes *outside the gut* are chiefly peritoneal adhesions following probably post-operative appendicitis or some surgical operation, or else the condition is due to a compression by a tumour, such as a retro-flexed uterus, &c.

The next condition we must recognize as soon as possible—it is *intussusception*. Our chief difficulty will be to distinguish it from colitis. Both frequently occur in babies about one year old; both are frequently preceded by a slight alimentary disturbance, such as an attack of vomiting, or slight diarrhœa. Blood and mucus are passed in the stools of both patients. Tenesmus is present in each. Fever is often present slightly with intussusception, but is much more common with colitis. A tumour can be felt in most cases of intussusception, but it is said not to be palpable even with an anæsthetic in one case out of every four. A tumour may possibly be felt in colitis, and if so, then the condition is one of spastic sigmoid. There is, however, a great difference between these tumours. That of intussusception is large, sausage-shaped, hardening and softening on palpation, whilst that of colitis is small, about the size of the little finger. It does not harden and soften when manipulated. The crucial point, however, to distinguish them is to determine whether bile is present with the blood and mucus. If it is present after the first and second motion, colitis or chronic intussusception is present; if absent, acute intussusception is present. This was found to be so at the London Hospital in thirty-six cases out of forty-three. Bile was present in five cases, of which four were chronic intussusception; in one case the sign failed.

Again, five cases of colitis were admitted as intussusception. Bile was present in the blood, and mucus in four of them; in the fifth case it was found all along the colon at the post-mortem examination.

A second very important distinction is the character of the onset. An acute intussusception has always a sudden onset; acute colitis generally a gradual onset. Again, unfortunately, the two may co-exist.

A *volvulus* nearly always occurs in men; the proportion is four to one. The onset of severe pain is here sudden, but not so much so as in strangulation due to bands. There is great distension, the pain has colicy relapses. Tenesmus is frequently present. Tenderness, due to peritonitis, appears early.

We must now briefly touch upon the acute diseases of the large intestine.

Colitis usually yields to treatment, and illustrates another condition in which the onset is acute. Mucus and blood appear in the stools. It is useful to remember that patients who have suffered from dysentry are liable to colitis. The sudden onset and the mucus character of the stools distinguish it from enteric fever.

We must not forget malignant disease, nor chronic arsenical poisoning with peripheral neuritis as one of its distinguishing features.

We next must consider dilation of the colon. This may be due to gases: In this case probably other trouble co-exists, possibly enteric or peritonitis. This may be due to solids: this has been dealt with under obstruction, *i.e.*, fæcal masses, foreign bodies, etc. Or it may be due to an organic obstruction in part of dilated gut. This will hardly lead to an acute condition of its own accord, and obstruction in the gut-wall has been discussed; or, lastly, there may be the so-called ideopathic dilation of the colon. This is a very rare condition which will hardly be diagnosed before operation. It may be possibly suspected in a patient who has been constipated all his life, and who suffers occasionally from sudden distension which can be relieved by passing a rectal tube into the colon. If X-rays are available, the size of the colon may be observed after feeding the patient with bismuth-carbonate, and then examining him with a screen.

We must briefly mention accidents as the cause of some acute abdominal conditions. We shall always be able to obtain details of the nature of the accident, whether a wheel passes over the abdomen or the patient is squashed between two buffers, or whether he fell from some height. We shall suspect rupture of some viscus if our patient is collapsed as the result, or if he shows signs of peritonitis. We must not forget the possibility of hæmorrhage, and therefore note the colour and pulse-rate and pulse-volume of our patient at frequent intervals. The small intestine is more frequently infused than the large in these traumatic cases.

The last trouble we must consider which may give rise to an acute abdominal condition is a *subphrenic abscess*. We have all the signs present of suppuration—that is, increased temperature, moist perspiring skin, and pain, with a marked leucocytosis. The only question to decide will be, Where is the abscess? If there is no gas in the abscess cavity, it is most likely to be mistaken for either a solid tumour or an empyæma. If it does contain gas, it will be mistaken for a pneumothorax. In these cases the clinical history of the case is most important in order to obtain evidence of the lesion which has lead to this trouble.

Subphrenic abscess frequently follows ulcerations and perforations of the stomach or bowel, including the appendix; also lesions of the gall bladder and its duct. It is rarely due to bacterial infection alone. We must look for local bulging of the ribs without the displacement of the heart to the opposite side, associated with pyrexia and a leucocytosis. As an aid to diagnosis the X-rays may be very valuable in these cases.

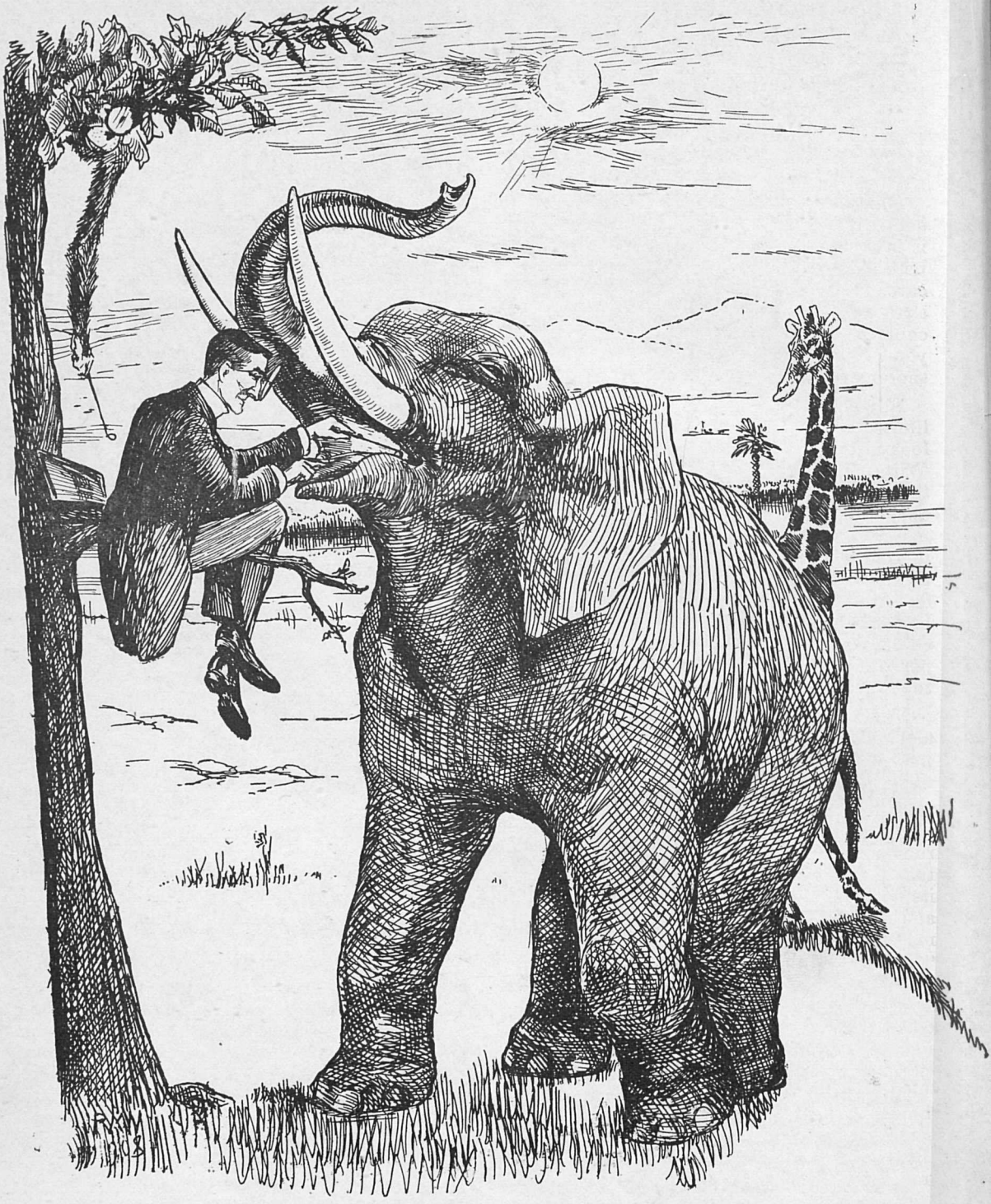
This concludes a list of the more acute abdominal conditions that one may meet in practice. It emphasises how difficult it may be to make a diagnosis. It urges the necessity for a thorough examination of the patient. Mistakes even then occur.

It cannot be expected that this thesis should throw any new light on such abstruse and difficult cases. If, however, some of the pitfalls have been re-exposed to light, which have been gathered from the teachings and writings of those men who have had the greatest experience in these conditions, then, perhaps, somebody besides the writer—possibly a patient—may benefit by the statements made in this paper, and then this thesis will not have been written in vain.

Papers by Guy's Men.

Observations on the Opsonic Index in Pulmonary Tuberculosis. By D. Lloyd Smith, M.B. Lond., J. A. D. Radcliffe, M.B., R.U.I., Douglas Elder, M.B. Liverp., and Alan Crossley, M.A. (Illustrated.)—*The Lancet*, 18th July, 1908.

A Post-Graduate Lecture on General Suppurative Peritonitis. By Lawrie McGavin, F.R.C.S. Eng.—*The Clinical Journal*, July 8th, 1908.



IN THEIR HOURS OF EASE.

The Holiday Occupations of Eminent Persons.

"Say Ah—a!"

Trigeminal Neuralgia, Secondary to Diseases of the Teeth.

DENTAL CLINICAL LECTURE BY MR. MONTAGU F. HOPSON.

GENTLEMEN,—I have chosen this as the subject of my brief lecture this morning, because it is a condition which you will be called upon both to diagnose and to treat very early in your careers; further, it is one which, more frequently than any other, will bring you into intimate contact with the medical practitioner. Hence, you see, it is of importance that you should be thoroughly conversant with it.

Now, before considering trigeminal neuralgia, limited in origin to some dental lesion, let us look at it from a somewhat broader standpoint. With practically one exception, and that due to the present limitations of our knowledge, we are able to say that it is not a disease *per se*, but is merely a particular symptom of a variety of morbid conditions, all of which are remote from the site of the pain. If you ask me for a definition, I would say, it is a shooting, boring, burning pain, nearly always paroxysmal in character, felt along the course of a particular nerve and its branches, and not referred solely to its periphery.

Now what are the causes of such a pain felt along the branches of the fifth nerve, and how may we classify them?

I have here a diagram of the nerve, just to refresh your memories, as well as my own, as to its origin, distribution, and function. You will remember that it resembles a spinal nerve, in that it arises from two roots, has a ganglion on its posterior or sensory root, within the cranium, and that it is a mixed nerve. The anterior, or motor root, has its superficial origin in the "Pons," its deep origin in the floor of the fourth ventricle, and partly from cells at the side of the aqueduct of Sylvius. The posterior or sensory root has its superficial origin in the "Pons" also, whilst its deep origin may be traced back to the medulla. The two roots run forward; the fibres of the sensory root enlarge to form the Gasserian ganglion, while the motor root passes beneath this ganglion without having any connection with it, but joins outside the cranium with one of the trunks derived from it.

The main branches from the Gasserian ganglion are:—

1. Ophthalmic—supplying the eye, lachrymal gland, nasal fossæ, integuments of eyebrow, forehead, and nose, etc. Its function is sensory. With it is connected the ophthalmic or lenticular ganglion, the sensory root of which is derived from the fifth, the motor root from the third, the sympathetic from the cavernous plexus.

2. Superior maxillary—supplying sensation to the middle part of the face, the upper teeth, etc. With it is connected the spheno-maxillary, or Meckel's ganglion, which has a sensory root from the fifth, a motor root from the seventh, and its sympathetic from the cerebral plexus.

3. Inferior maxillary—which is the sensory nerve of the lower jaw and teeth, lower lip, chin, etc., whilst it is also motor to the muscles of mastication.

With this division are connected two ganglia, the otic, which has its sensory root from the fifth, its motor root also from the fifth, and its sympathetic from the meningeal plexus. The sub-maxillary ganglion derives its sensory root from the fifth, its motor from chorda tympani and seventh, its sympathetic from the facial artery plexus. So you see that, by anastomosis and through its ganglia, it has communication with several other cranial nerves, as well as with the sympathetic. The functions of the nerve are sensory, motor, secretory, and trophic.

Now trigeminal neuralgia is spoken of as major or minor, according to its type.

Neuralgia quinti major, sometimes called epileptiform neuralgia, is the most frightful of all neuralgias, the pathology of which has still to be elucidated; it appears to yield to no treatment short of surgical interference, which may be as grave as excision of the Gasserian ganglion. It certainly is not of dental origin, inasmuch as all the teeth have, on occasions, been removed without affording relief.

Neuralgia quinti minor may arise from—

1. Morbid conditions of the teeth and their attachments.
2. Morbid conditions of the tongue and oral mucous membrane.
3. Morbid conditions of the eye.
4. " " ear.
5. " " nose, antrum, and frontal sinuses.
6. Morbid conditions of the abdominal and thoracic viscera.
7. Organic lesions of trigeminal nerve or its roots (tumours, etc.).

8. Secondary to general diseases, *i.e.*, anæmia, diabetes, rheumatism, influenza, hysteria and other mental states.
9. Pregnancy.
10. Toxic conditions, *i.e.*, malaria, syphilis, alcoholism, lead poisoning, etc.

This is a formidable list, but we are concerned with the elimination of one only, viz., *trigeminal neuralgia secondary to dental disease.*

I have already alluded to the character of the pain; it is sudden in its onset; flashes along the course of one of the branches of the fifth nerve, focussing itself at one particular spot, increasing in intensity, lasting for a few minutes or some hours, and usually terminating as suddenly as it arose. It may commence without any apparent exciting cause; on the other hand, the incidence of a direct draught, the sudden change of temperature from the cold winter air to that of a warm room, or the act of stooping down to tie up a boot, may induce an attack.

All these minor neuralgias are markedly affected by the general states of the body. They are usually at their worst during hunger and fatigue. Hence the attacks are frequently "periodic."

Someone has defined dental neuralgia as toothache plus debility. Certainly all the general diseases I have mentioned, together with pregnancy, may act as predisposing causes of dental neuralgia, either by lowering the general vitality, or by being themselves predisposing causes of caries, or some other dental trouble.

A paroxysm of pain may be accompanied by "vaso-motor" changes. Thus there may be flushing of the face, sweating, and lachrymation on the affected side. Salivation may also be present, and, in some instances, the conjunctiva is injected.

"Muscular spasm" is not uncommon. It may be either clonic or tonic. Some of you probably saw a patient in the Conservation Room the other day, who was under the care of Mr. Parfitt. She was a woman of middle age, suffering from persistent neuralgia on the right side of her face. The pain was obviously accompanied by unilateral flushing of the face and lachrymation from the right lachrymal gland. Further, she had a well-marked blepharospasm, that is to say, twitching of the eyelid.

"Trophic changes" may also occur as the result of continued attacks; thus the hair over the affected area may turn white; more rarely there may be an increase in growth, or it may fall out.

"Hyperæsthesia" of definite areas may exist.

Now, a patient, probably a woman — for neuralgia is commoner among women than men and between the ages of twenty and sixty—may be referred to you by a medical man. She has been suffering from trigeminal neuralgia; treatment by drugs has done her no good. You are asked to ascertain if there is any dental cause of her trouble. The patient may be confident that her teeth are all right, because she has had no toothache.

Your first inquiry will be as to the seat of the pain. There are certain spots about the head and face which we are accustomed to speak of as neuralgic foci, and, inasmuch as reflex dental pain never crosses to the opposite side of the face, the site of the pain is an important aid to diagnosis. We know further, from clinical experience, that certain pain spots are commonly associated with certain teeth. So you see we begin to narrow down the field of our investigation.

"Neuralgic foci" correspond to: (*a*) The point of exit of a nerve from a bony foramen (supra-orbital, infra-orbital, mental); (*b*) the situation of superficial nerve plexuses (over molar bone and temple), and, very commonly, in and in front of the ear.

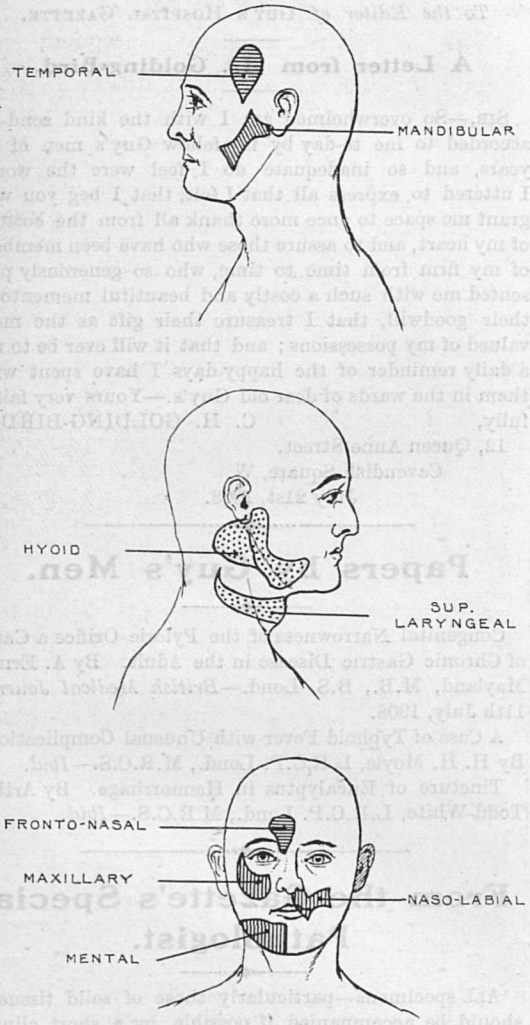
These pain spots are associated with the teeth thus:—

Upper incisors, „ premolars, „ molars	Infra-orbital	Eye and supra-orbital	
	Upper part of temple		
Lower incisors	Mental		Parietal
„ premolars, „ molars, (especially third molars)	Mental or ear, shooting down neck to shoulder		

There remains also to be noticed that occasionally disease in one tooth gives rise to pain in another; *i.e.*, pain arising from a lower third molar is not infrequently referred to the premolar.

Dr. Head has mapped out the head and face, as well as other parts of the body, into what are termed "segmental areas of hyperæsthesia;" that is to say, skin areas which become tender in association with disease of certain viscera. The extent of such areas may be ascertained by going carefully over the skin surface with the blunt head of a pin, or, in those situations which are covered with hair, by gently

pulling the hair. These areas he links with the teeth thus:—



Upper incisors.	Fronto-nasal	Lower incisors.	Mental
„ canine.	Naso-labial	„ canine.	„
„ 1st premolar.	„	„ 1st premolar.	„
„ 2nd „	Temp. or Maxillary	„ 2nd „	Doubtful
„ 1st molar.	Maxillary	„ 1st molar.	Hyoid
„ 2nd „	Mandibular	„ 2nd „	„
„ 3rd „	„	„ 3rd „	„ or S. Laryngeal

The diagram shows the maxima of these areas.

Now what conditions of the teeth and their attachments may give rise to the symptoms we have just considered?

a. Morbid conditions of the pulp, *i.e.*, irritation, inflammation, suppuration, polypus, degeneration, intrinsic calcification.

b. Lesions of the dentine, *i.e.*, caries, erosion, abrasion, attrition, fracture.

c. Lesions of the cementum, *i.e.*, exposure from gum recession, caries, erosion, abrasion, absorption, exostosis.

d. Morbid conditions of the periodontal membrane, *i.e.*, inflammation, acute and chronic.

One or other of these conditions may be obvious so soon as you examine the teeth. It is necessary, however, that your examination be systematic and thorough. With a sharp-curved probe go carefully over the teeth, turning your attention first of all to those which, from the site of the pain, are most likely to be involved. Search for hidden cavities, especially in the approximal and bucco-cervical regions. Pass some waxed silk between the teeth. If it cuts or frays your suspicion should be aroused. An electric mouth-mirror, used in a darkened room, is of the greatest possible service in revealing hidden approximal cavities. If you fail to find cavities, submit each tooth individually to thermal tests; for heat, with a hot burnisher or pellet of hot gutta-percha; for cold, with absolute alcohol. Pay particular attention to those teeth with large fillings. Remember, also, that all live teeth, and under certain conditions some dead ones, respond to thermal tests. It is therefore necessary to regard the degree of response elicited.

Next eliminate the presence of periodontitis, either by percussion, by seizing the tooth between the finger and thumb and exerting lateral pressure upon it, or by allowing your patient to bite upon thick but narrow strips of card. These two last tests are also of some service in aiding one to diagnose exostosis.

The X-rays will reveal exostosis, absorption of the roots, fibrous thickening around the apex of a root, buried roots, etc.

Do not neglect to pass a bristle along open root canals, for live pulp elements may still exist high up near the apex.

Above all, more particularly if your patient be between seventeen and thirty, and the site of the pain is in and about the ear, or radiating down the neck, suspect an unerupted and probably impacted lower third molar. A sharp probe thrust into the gum at the back of the second molar may reveal its presence by striking enamel, the X-rays most certainly will, and may possibly indicate also absorption of the adjacent second molar.

In nine cases out of ten, the cause of dental neuralgia is to be found in some lesion of the pulp. Uncomplicated periodontitis rarely gives rise to it.

On the other hand, a state of oral sepsis due to the presence of septic roots, or chronic suppurative periodontitis, may be the cause of general disease, which in itself may be the exciting or predisposing cause of trigeminal neuralgia.

Reflex dental pain may not be confined to branches of the fifth nerve, but such cases are beyond the title of my lecture.

The appropriate dental treatment you are familiar with. It must be thorough. In certain states of the body a comparatively trivial dental lesion is sufficient to cause and maintain very obstinate neuralgias. If you cannot restore a tooth to a healthy condition, do not hesitate to remove it, and never "cap" a pulp which has given rise to neuralgia.

The treatment of any general condition predisposing to neuralgia, the exhibition of neuralgic specifics, are matters for the medical practitioner. It remains for you to treat and remove the peripheral irritation which is the exciting cause, co-operating with the medical practitioner in the treatment of any general condition acting as a predisposing cause.

Change of Address.

Dr. A. R. Beaumont, from The Royal Hospital, Bath, to St. Mary's Hospital, Paddington.

Mr. C. N. Doyle, L.D.S. Eng., from 42, Welbeck Street, W., to 57a, Wimpole Street, W.

Dr. H. E. Croker Fox, from Monywyke, Bincleavse, Weymouth, to Charlbury Lodge, near Weymouth.

Dr. Francis A. Godson, from Westbrook, Central Road, West Didsbury, Manchester, to Pinehurst, Barlow Moor Road, Didsbury, Manchester.

Dr. W. Gibson Parker, from 39, Park Hill Road, Haverstock Hill, N.W., to 2, The Avenue, Taunton.

Mr. R. P. Rowlands, M.S. Lond., F.R.C.S. Eng., from 6, St. Thomas's Street, S.E., to 12, Queen Anne Street, W. (After 8th August.)

Mr. T. Scott-Foster, L.D.S. Eng., from "Braemar," St. Helen's Parade, Southsea, to "Thirlestane," Bembridge Crescent, Southsea (private), and 85, Commercial Road, Southsea (professional).

Dr. H. Stanley-Jones, from 6, Abbeville Road, Clapham Park, to "Bramfield," 2, Abbeville Road, Clapham Park, S.W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

A Letter from Mr. Golding-Bird.

SIR,—So overwhelmed am I with the kind send-off accorded to me to-day by my fellow Guy's men of all years, and so inadequate do I feel were the words I uttered to express all that I felt, that I beg you will grant me space to once more thank all from the bottom of my heart, and to assure those who have been members of my firm from time to time, who so generously presented me with such a costly and beautiful memento of their goodwill, that I treasure their gift as the most valued of my possessions; and that it will ever be to me a daily reminder of the happy days I have spent with them in the wards of dear old Guy's.—Yours very faithfully,

C. H. GOLDING-BIRD.

12, Queen Anne Street,
Cavendish Square, W.
July 21st, 1908.

Papers by Guy's Men.

Congenital Narrowness of the Pyloric Orifice a Cause of Chronic Gastric Disease in the Adult. By A. Ernest Mayland, M.B., B.S. Lond.—*British Medical Journal*, 11th July, 1908.

A Case of Typhoid Fever with Unusual Complications. By H. H. Moyle, L.R.C.P. Lond., M.R.C.S.—*Ibid.*

Tincture of Eucalyptus in Hæmorrhage. By Arthur Todd-White, L.R.C.P. Lond., M.R.C.S.—*Ibid.*

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

"G.-B."

G.-B.

GUY'S HOSPITAL has always reckoned among its especial blessings a tradition of cordial and unaffected relations between all ranks of its workers, a sentiment which in time past has contributed in a large degree to the formation of that individuality of its corporate hospital life that makes the "Guy's man" a distinctive figure in the medical world.

There has been no more devoted upholder of this tradition than Mr. Golding-Bird, and by his retirement from the active list, Guy's loses more than his distinguished services to the Surgical side of the hospital; for, to many generations of hospital men, "G.-B." has embodied, in an eminent degree, all those qualities we are happy to associate with a "Guy's man" at his best.

"G.-B."—Mr. Golding-Bird will doubtless forgive us, if, from force of habit, we fall back upon the initials which have become more familiar to us than his proper style—"G.B." has always dissociated himself from the temper of those demi-gods formerly, perhaps still, to be observed in other hospitals, who perpetually hold at arm's length their disciples, lest for a moment they should tread upon the hem of the trailing mantle of the great one's dignity. "G.-B.'s" method has been otherwise: house-surgeons, dressers, and ward clerks have always found him accessible, and their respect has grown *pari passu* with their regard.

With his patients, too, he has exercised the same qualities. His constant urbanity never failed to win the confidence of the most sullen new-comer whose distrust of hospital practice has subsequently disappeared in his anxiety for a rapid recovery in order to meet at the earliest opportunity the bonesetter or the vendor of back-ache pills who had previously "treated" his case. "G.-B." has made enthusiastic converts in his wards.

Perhaps that *Æquanimitas* Professor Osler describes finds its best interpretation when "G.-B." is in the Operating Theatre. How many of his old dressers can remember an occasion when the operator's unruffled serenity has deserted him, even when the case presented unforeseen difficulties? How many clerks recall aught but smiling courtesy when their rawness made them rather less than useful? *One* clerk and dresser remembers with gratitude that he was invariably treated far above his deserts.

Is it necessary to say much of those Tuesday afternoon rounds? Those occasions will be remembered by many more than the men who have served directly under "G.-B.," and they can testify to the sound teaching they received and to their disconcertion when confronted with that simple question, "Why?" Perhaps, too, they may recall some of those little anecdotes, gathered from the varied experiences of outside practice, whose advent somehow caused Sister to discover unexpected duties for her charges at a distance down the ward.

Former dressers will not need to be reminded of the kindly reception extended to them by Mr. and Mrs. Golding-Bird, at Queen Anne Street, on that most pleasant occasion, the Firm Dinner.

All over the world are men whose thoughts at times must turn to this hospital: perhaps to Guy's, before the days of white tiles and tessellated paving, the old septic lovable place, before the kaleidoscopic changes of late years threatened to metamorphose the old fabric into something as clean and spick-and-span as a Model Dairy—for the *Expression of the Milk of Human Kindness*, as "G.-B." would say. They will unite with the Guy's Hospital of the present day in wishing the best of health and happiness to Mr. Golding-Bird and — the supreme head of the "G.-B." firm — Mrs. Golding-Bird.

Reviews.

The price of books submitted for review should in every case be stated.

The Practice of Medicine. By Frederick Taylor, M.D. (J. & A. Churchill.) Eighth edition. Price 15s. net.

We have received a copy of the eighth edition of Dr. Taylor's well-known text-book. It is unnecessary to do more than repeat what we have often said before in reviewing earlier editions of the book—that it has always appeared to us by far the most suitable text-book of medicine for the student beginning the study of medicine. It is not too short; it is not too long. Nothing of importance is left out, nothing unnecessary included. One cannot too highly praise the good judgment of the author, which has enabled him to keep so just a proportion between the different divisions of the large subject of medical practice. We think that to no other text-book of medicine, solely the work of one man, can the same praise be given in the same measure. In other works of similar size and aim, it is almost always possible to glean in what particular direction the author's own interests lie. Neurology may bulk too largely, to the exclusion of dermatology, or the cardiac system be enlarged at the expense of the respiratory. It is especially possible for us at Guy's Hospital, with an intimate and personal knowledge of its author, to recognise how little he has allowed his own keen interests and attractions to bias his sense of proportion. In the present edition, much that is new has been added. The introduction of matter dealing with opsonins, heart block, congenital hypertrophic stenosis, and other eminently controversial subjects, has brought the work well up to date, and has been effected, moreover, without disturbing the just proportion to which we have referred. A new feature is the introduction of several plates of X-ray photographs, the work of Dr. Jordan, illustrating the appearances of certain pulmonary, cardiac and vascular diseases.

Quain's Anatomy. Vol. I. Embryology. By T. H. Bryce, M.A., M.D. (Messrs. Longmans, Green & Co.).

For years "Quain's Anatomy" has held a prominent and, to a great extent, a unique position among anatomical text-books, and the present edition bids fair to uphold this tradition. The tenth edition was published in 1898; since then, embryology has advanced so much that the volume on this subject was to a considerable extent out of date. The present volume, the first of four which are to form the eleventh edition, brings together all the recent work on embryology, and is now the most comprehensive English book on the subject.

Dr. Bryce has divided the volume into two sections. In the first he deals with the general development of the ovum, giving particular attention to the nuclear phenomena in the process of fertilisation, the formation of the germinal layers, and the early stages in the development of the various systems of the body. A notable feature of this section is a most interesting history of development, from an ovum of the first week to a full-term fœtus, the various stages being excellently illustrated. The second section treats in detail of the formation of all parts of the body; the organs and systems are dealt with separately, and the descriptions of their development are built on the best and most recent investigations. This section is profusely illustrated, and a large number of the pictures are designed from embryos modelled on the reconstruction method.

The Physical Signs of Diseases of the Thorax and Abdomen. By James E. H. Sawyer, M.D. (Ballière, Tindal and Cox.) Price 5s. net.

We have received a copy of this work, by Dr. James Sawyer, of Birmingham, and have little to say of it but praise. It is, perhaps, not very novel in plan, but is content to follow the arrangement which is to be found in almost all text-books of medicine. After a short and accurate chapter upon the topographical anatomy of the abdomen and thorax, the book proceeds to give a clear account of what can be learnt in various diseased conditions by the different methods of examination, inspection, mensuration, percussion, palpation and auscultation. As a rule, the author is careful to explain the exact significance of the different physical signs. It is always difficult for the beginner to realise the exact amount of information conveyed to him by so-called physical signs. The dulness and bronchial breathing at the base of the lung do not tell him that the patient has pneumonic consolidation of his lung, but only that the alveolar air has been removed. The further deduction that this is due to pneumonic consolidation is from the patient's symptoms and the physician's experience. By its careful explanations of the meaning of the different physical signs, the book should be of great use to the student who finds difficulty in appreciating their true meaning and value.

Proceedings of the Royal Society of Medicine. Vol. I., No. 8, June, 1908. (Messrs. Longmans, Green & Co.) 7s. 6d.

The June number of the Proceedings is of more than usual interest, containing as it does so many features which bid fair to be of great value in both the fields of surgery and medicine. One is struck, in reading the paper contributed by Mr. Ballance to the Clinical Section, by the great strides which the surgery of the circulatory system is making. His case of end-to-end anastomosis of the femoral artery and vein in a case of senile gangrene, though ending fatally, from reasons little understood, is most instructive. The bibliography which accompanies the article will be appreciated by those interested in

arteriorraphy, etc. Almost immediately following is a report of a case of rupture of the upper cord of the brachial plexus at birth, treated by excision of the cicatrized end and junction of the divided ends; the result is gratifying in the extreme. Mr. Ballance was again the surgeon. In still another remarkable case, one of a gross lesion of the post-central gyrus, associated with astereognosis, did this surgeon operate. He removed, after an exploratory operation, a diseased area of meninges—thickened infiltrated pia-arachnoid—over the left post-central gyrus: the subjacent cortex was likewise taken away. At the present time the patient, who previously was aphasic, shows but the slightest slurring in his speech; in fact, everything but the astereognosis (he fails to recognise objects placed in his right hand) is almost normal. Mr. Fagge showed two cases, one a recurrent sarcoma, in the removal of which parts of the femoral artery and vein were excised, and the other, a femoral aneurism, treated by excision both of the sac and the femoral vein. Verily, the Clinical Section is full of interesting reading.

Those keen on Ionic medication should peruse Dr. Sloan's article on this form of treatment in certain gynæcological conditions.

Sir Frederick Treeves contributes to the Epidemiological Section a paper full of literary charm, and of great interest to Public Health men, on Preventive Medicine at Panama.

Dr. Latham's paper on the Administration of Tuberculin, etc., by the mouth, which we noticed when it appeared, is discussed at length by members of the Medical Section. We strongly recommend this discussion to the notice of our readers. The field which is opened up by this line of medication is most extensive, and the co-operation of willing observers will soon put to the test its real value.

The Surgical, Otological, Odontological, and Laryngological sections are full of good things.

As to the production, it suffices to say it maintains its high standard.

Papers by Guy's Men.

Acute Abdominal Lesions of Pelvic Origin. By Thomas G. Stevens, M.D., B.S. Lond., M.R.C.P. Lond., F.R.C.S.—*The Clinical Journal*, 22nd July, 1908.

A Case of Enchondroma in the Tendon-sheath of the Finger. By R. R. Walker, M.A., B.C.—*Ibid.*

BOOKS RECEIVED.—McLachlan's Applied Anatomy, 2 vols.; Sir James Sawyer's Maladies of the Heart; Vol. I. of A System of Syphilis, edited by Mr. D'Arcy Power and Mr. Keogh Murphy; Examination Questions of the University and Conjoint Board, Edinburgh; No. 8, Proceedings of Royal Society of Medicine; British Dental Journal, 1st and 15th July; The Practitioner, July; Journal of the Royal Army Medical Corps.

In Lighter Vein.

IN the recent paper for the Beaney Prize in Pathology, question 6 was as follows.—

> "What do you know of pathological interest concerning polychromatophilic degeneration, bilharzia, anti-amboceptors, Kitasato, compound granular corpuscle, David Bruce, milk spots, Weigert, Anopheles, acute traumatic malignancy, pèbrine, and A. E. Wright."

The following answer was found in the waste paper basket written by a candidate who did not show up his paper:—

Poly chromatophilic degeneration is a phrase used to describe corpuscles which the experimenter has been unable to stain properly.

Anti-amboceptors are hypothetical anti-bodies for imaginary substances which are supposed in all probability to have a definite shape and size. They were introduced to bolster up the theories of immunity.

Kitasato was a Japanese ballet dancer, who was enamoured of B. Diphtheria and B. Tetani in turn; but the production of her antitonic phantasia brought about a rupture between them both.

Milk spots show well on a black cloth, and once they have made their appearance are most difficult to eradicate.

Anopheles was the son of Hippocrates, and is renowned for his careful and exhaustive study of the malarial parasite. All the details of the sexual cycle of this pernicious protozoon were perfectly familiar to him long before the researches of Ross. His knowledge of the Hæmamœba was, however, lost sight of, in spite of the fact that Anophedes never lost an opportunity of transmitting it to his contemporaries.

A compound granular corpuscle is a cell or corpuscle which is granular and of great interest; in fact, of compound interest.

Weigert is famous for his staining methods. They have, however, palled since his day.

Acute traumatic malignancy was the crime usually preferred against Prince Rupert's followers by Cromwell's Ironsides. About the trauma there were plenty of witnesses, and the acuteness of the malignants was obvious.

David Bruce was a Scotchman who studied the pathological pertinacity of spiders. He is also reported to have recommended trypanosoma, by intravenous injection, as the best and most lasting cure for insomnia.

Bilharzia? Bill Harzia was the founder of the race of Borough loafers, and is chiefly remarkable for the frequency with which he used the adjective b——y. Hence Bill Harzia is always associated with hæmat—— something or other.

Few diseases have wrought such havoc in the South of France as pébrine. The microsporidion has a long latent period and a large refractive index.

Hippocrates we know, and Anopheles we know; but who is A. E. Wright? What had he to do with pebrine?

BAW BEE.

Sport.

Cricket.

FIRST XI.'S VISIT TO MAJOR LAYCOCK'S.

A SHORT ACCOUNT.

On the 13th inst., the annual visit to Major Laycock's took place. The team was weakened by the absence of Lee and Munden; the former owing to exams., the latter to first-class cricket. Mr. Elliott came as scorer. We started by the 3.25 from King's Cross, and at Newark were joined by Harris, looking very fit after a quiet night in Nottingham. He wiled away the remainder of the journey with terrifying stories of last year's motor drive from the station up to Wiseton, so that most of us were more or less uncomfortable by the time we reached Retford Station. Harris's tales of hairbreadth escapes proved, luckily, a wee bit poetical; but the way that nine miles of sinuous high-road was accounted for was very near his mark.

On reaching Wiseton we were met by the butler, who informed us that Major Laycock had wired his inability to get back until Tuesday, but requested us to make ourselves at home meanwhile. The hour or so before dinner passed quickly enough in strolling about the beautiful grounds, and visiting the stables.

In the absence of our host, Kahlenberg presided at a regal repast; a host of waiters ministering to our wants with such unfailing certainty that conversation waxed brilliant. Young and Elliott were especially scintillating, while Montgomery showed his points in an impassioned defence of Knaresborough, and other Yorkshire villages, against all comers. It appears he hails from somewhere up north.

After dinner, Clarke gave us a tasteful rendering of Miss Maud Allan's dancing, to the music of a splendid electric organ in the hall. He was loudly applauded, and the infection spreading, some excellent waltzing resulted. The remainder of the evening went in bridge and billiards, varied every now and then by musical sketches by Montgomery.

At 1.30 a.m., Kahlenberg, who had lost heavily at bridge, refused to play any more. He said it was bed time. After making a great fuss, threatening to turn the lights out and hide the billiard balls, he drove us all upstairs. We were told that cricket was impossible without sleep, and that it was his duty to see that we got it. About an hour later, when everything was quiet, he woke up everyone in turn in search of an "Annual," which he wanted to read in bed.

Play commenced at 11.30 on Tuesday. We won the toss, and went in on a wet wicket. Birks and Medlock opened the innings. Birks started hitting immediately, and scored at a tremendous rate, especially to leg. His innings of 96 was the finest display of the day, and a real good exhibition. Of the rest, Medlock and Montgomery did best. All out in time for lunch for 173. We succeeded in dismissing nine of the opposition for 205 before drawing stumps.

Major Laycock arrived during the afternoon, and presided at dinner in the evening. His varied experiences all over the world, including the Transvaal war, make him a most delightful host.

After dinner we adjourned to the billiard room, where Clarke and Elliott gave an exhibition, while Kahlenberg "marked." After several hours, amid breathless excitement, Elliott made the winning hit, and the fifty went up, amid great applause. In the course of a discussion following this game, it leaked out that Charlton had been to Australia, and a channel was thus opened for a most interesting series of anecdotes about our famous Colony. Charlton proved himself conversant with the birth, death and marriage details of every cricketer for the last thirty years, at least.

The following day, after disposing of the last wicket in the first few overs, Birks and Medlock again opened the scoring for Guy's. This time, owing largely to the treacherous condition of the wicket, we could do nothing right, and were dismissed for the insignificant total of 89, leaving our opponents 41 to make to win. This they, needless to say, succeeded in doing, though for a moment it looked like a possibility of getting them out.

After the match had been decided, each side went in for one and a quarter hours, just to enliven the spectators. Hitting was the order of the day, and while we were in the game resembled tip and run more than anything. Here again, alas! we were beaten.

The usual programme of billiards and bridge was varied on Wednesday night by a diabolo display by Birks and Clapperton in the billiard room. Though without spools, these two masters gave a striking exhibition of the game in all its subtleties; utilising each other's persons and surrounding furniture with equal ease. Later on, Birks, having by uncontrollable circumstances lost his partner, continued the entertainment alone far into the night. His grief at the loss of his dear friend was at times quite plaintive.

We all retired to bed with heavy hearts and somewhat dragging steps on this the last evening of a most delightful trip. Though the cricket went against us, yet the visit will always be remembered with gratitude to Major Laycock as a splendid success.

GUY'S v. MAJOR LAYCOCK'S XI.

On the 14th and 15th of July, the Hospital team were the guests of Major Laycock, at Bawtry. We were unfortunately beaten by a strong team got together by our host. Birks played very well for the Hospital, scoring 96 out of the first 110 runs.

GUY'S.

C. H. Medlock, c Bradshaw, b Guyler	21	c Hall, b Goodacre	15
A. H. Birks, c Smith, b Musk	96	b Hall	3
R. Montgomery, c Bradshaw, b Guyler	21	b Goodacre	17
P. C. Charlton, c & b Musk	2	c Goodacre, b Hall	12
H. V. Gibbons, st Stapleton, b Guyler	14	c Hall, b Guyler	5
W. T. Clarke, b Hall	9	b Hall	12
J. F. Young, b Guyler	3	c Musk, b Hall	9
J. H. Clapperton, b Guyler	1	lbw, b Hall	0
H. L. Duke, b Hall	1	c & b Goodacre	0
F. Kahlenberg, not out	5	c Bradshaw, b Goodacre	5
P. S. Humm, c Batty, b Hall	0	not out	0
Extras	0	Extras	11
Total	173	Total	89

MAJOR LAYCOCK'S XI.

W. B. Goodacre, c Kahlenberg, b Clapperton	80	c Medlock, b Kahlenberg	10
J. Stapleton, lbw, b Young	14	not out	4
R. D. Bradshaw, st Birks, b Young	0	not out	20
P. Hall, c Birks, b Charlton	19	st Birks, b Charlton	7
W. H. Copestake, c Kahlenberg, b Charlton	49		
W. Simpson, c Gibbons, b Clapperton	0		
D. Smith, b Kahlenberg	8		
E. Batty, lbw, b Charlton	26		
H. C. Farmer, not out	7	b Kahlenberg	2
—. Guyler, run out	4		
—. Musk, b Charlton	3		
Extras	11	Extras	1
Total	221	Total (3 wickets)	44

GUY'S v. ST. THOMAS'S.

The Final for the Hospital Cup was played at Winchmore Hill on the 20th and 21st inst., and ended in a win for St. Thomas's. The ground was very soft after the recent rains, and all the batsmen seemed to be lost on a slow wicket. For St. Thomas's Morcom took 11 wickets for 54 runs, while for Guy's Charlton captured 11 for 109 runs. Gibbons and Montgomery made a splendid effort to pull the game out of the fire after everyone else had failed.

ST. THOMAS'S.

F. M. Neild, c Gibbons, b Clapperton	13	c Gibbons, b Charlton	10
W. B. Laird, c & b Charlton	27	c & b Charlton	13
D. M. Gibson, c & b Charlton	5	c Clarke, b Charlton	6
E. A. Seymour, run out	38	run out	15
W. Weir, c Digby, b Clapperton	1	b Charlton	2
R. F. Bowes, c Lee, b Kahlenberg	15	c & b Digby	0
L. Meakin, b Charlton	2	st Montg'ry, b Charlton	19
C. G. Whorlow, c Lee, b Charlton	0	c Gibbons, b Clapperton	1
A. F. Morcom, not out	6	c Munden, b Charlton	24
W. Shipton, b Kahlenberg	3	run out	13
H. L. Padden, c Montgomery, b Charlton	7	not out	2
Extras	4	Extras	8
Total	121	Total	113

GUY'S.

M. M. Munden, run out	14	c Morcom, b Padden	0
C. H. Medlock, c Meakin, b Morcom	18	c Neild, b Meakin	11
H. Lee, b Morcom	9	b Morcom	0
A. H. Birks, b Morcom	1	b Morcom	7
R. Montgomery, lbw, b Morcom	2	b Bowes	21
W. E. S. Digby, c Laird, b Morcom	5	b Bowes	0
H. V. Gibbons, b Padden	9	b Morcom	53
P. C. Charlton, b Padden	4	b Morcom	2
W. T. Clarke, c Neild, b Padden	7	not out	0
J. H. Clapperton, not out	5	b Morcom	0
F. Kahlenberg, run out	3	b Morcom	0
Extras	2	Extras	5
Total	79	Total	99

GUY'S v. BECKENHAM.

Played at Honor Oak Park on July 11th, when we met with our third reverse for the season.

BECKENHAM.

L. H. C. Dermer, b Digby	29
F. D. Browne, b Clapperton	12
K. R. McCloughein, c Clapperton, b Clarke	86
H. Z. Baker, b Digby	74
W. A. Powell, c Montgomery, b Clarke	25
E. N. Fuller, b Montgomery	14
A. A. Torrens, c Medlock, b Montgomery	5
J. Todd, not out	1
J. C. Williamson, not out	4
Extras	15
Total (for 6 wickets)	265

Innings declared closed.

J. C. Stevens and F. G. Tomms did not bat.

GUY'S.

M. M. Munden, b Baker	3
C. H. Medlock, b Baker	7
H. Lee, b Torrens	3
R. Montgomery, c Todd, b Torrens	8
W. E. S. Digby, c Fuller, b Torrens	15
W. T. Clarke, b Baker	5
H. M. Bundey, b Baker	1
W. E. Fox, c Fuller, b Torrens	2
C. G. Morris, c Dermer, b Torrens	3
J. H. Clapperton, b Torrens	23
F. Kahlenberg, not out	10
Extras	21
Total	101

BATTING AVERAGES.

Name.	Innings.	Not out.	Total.	Highest score.	Average.
A. H. Birks ...	12	1	461	121*	41·91
M. M. Munden ...	23	0	690	131	30·00
R. Montgomery ...	24	1	637	95	27·69
H. Lee	13	0	338	89	26·00
P. C. Charlton ...	15	1	362	83*	25·84
W. T. Clarke ...	16	4	294	90*	24·50
C. H. Medlock ...	25	0	454	64	18·16
F. Tooth	15	4	198	55	18·00
F. Kahlenberg ...	21	6	196	37*	13·06
J. H. Clapperton ...	19	3	145	23	9·69
Also batted:—					
R. G. Chase ...	3	1	102	46	51·00
A. C. Hancock ...	3	1	76	37*	38·00
H. V. Gibbons ...	5	0	105	53	21·00
F. D. Saner ...	8	1	72	35*	10·28
W. E. S. Digby ...	3	0	20	15	6·66

* Signifies "not out."

BOWLING AVERAGES.

Name.	Overs.	Maidens.	Runs.	Wkts.	Av'ge.
P. C. Charlton ...	259	36	696	58	12·00
J. H. Clapperton...	179	34	503	34	14·79
F. Tooth	154	23	464	30	15·46
F. Kahlenberg ...	438	103	1127	72	15·66
Also bowled—					
R. G. Chase ...	35	10	111	8	13·87
W. T. Clarke ...	16	0	71	4	17·75
W. E. S. Digby ...	15	1	60	3	20·00

RECORD FOR 1908.

Played.	Won.	Lost.	Drawn.
23	15	5	3

Rifle Association.

The "Bisley Cup" was shot for on Thursday, July 16th, in thoroughly unpropitious weather. Rain fell unceasingly from eleven o'clock onwards, and when shooting began at about six o'clock the light was almost as bad as it could be, if shooting were to be possible at all. All four Hospital teams "cracked up" pretty badly, but unfortunately Mary's kept their form somewhat better than did our own men. The final scores were:—

Mary's	246
Guy's	206
Bart.'s	195
Thomas'	165
Details of Guy's score:—	
H. L. Attwater	40
C. C. Holman	38
W. E. Wallis	37
C. B. Ticehurst	33
H. J. Henderson	30
L. L. C. Reynolds	28
	206

The "Lloyd Cup" was shot for at the United Hospitals Prize Meeting and was won by Mary's with a score ten points better than our own. Guy's:—

H. L. Attwater	98
H. J. Henderson	91
L. L. C. Reynolds	86
W. E. Wallis	75
	350

The "Armitage" also was won by Mary's, whose second score of 557 constitutes a new record for this series.

Swimming Club.

The semi-final round of the polo match was fixed for Thursday, July 16th, against Bart.'s, but they scratched at the last minute, as they could not raise a team.

The final for the team racing cup was swum off on Friday, July 17th, at St. George's Baths, between Charing Cross (holders) and Guy's. Guy's won by about five yards in 3 min. 39 sec. Teams:—

GUY'S.—H. H. Glover (captain), C. D. Roberts, G. B. Pritchard, and A. V. Moberley.

CHARING CROSS.—I. J. Hallinan, J. C. Hallinan, W. E. Hallinan, and P. D. Hamilton.

Pritchard and T. G. Hallinan led off, and Pritchard obtained a lead of three yards. Moberley and J. C. Hallinan went next, and Moberley kept the same lead. Roberts went off next with W. E. Hallinan, and increased the lead to five yards, and Glover swimming last, kept the same distance ahead of P. D. Hamilton to the finish.

Births.

FRIPP.—On July 19th, at 19, Portland Place, W., the wife of Sir Alfred Fripp, of a daughter.

PAYNE.—On July 16th, at Northwood, Alton, Hants, the wife of O. V. Payne, M.B., B.C., of a son.

Marriages.

FRENCH—FORD.—On July 9th, at St. John's, Bexley, Ronald Edgar French, M.A., M.B., B.S. Cantab., to Dorothy Brodie, third daughter of Edward Ford, Barrister-at-Law.

HANDLEY—RIGBY.—On the 18th July, at St. James's, Piccadilly, by the Rev. J. Hamilton Carson, M.A., Rector of Little Plumstead, Norwich, assisted by the Rev. Francis Cole, B.A., Curate-in-charge of St. Luke's, Great Yarmouth, W. Sampson Handley, M.S., F.R.C.S., of 12, New Cavendish Street, W., to Muriel, youngest daughter of the late Rev. Francis W. Clayton Rigby, Incumbent of St. George's, Great Yarmouth, and of Mrs. Rigby, Southtown, Great Yarmouth.

RICE—STENNING.—On July 16th, at Beckenham Parish Church, by the Rev. C. M. Rice, M.A., King's College, Cambridge, brother of the bridegroom, David Rice, M.D., Medical Superintendent of the Norwich City Asylum, second son of the late Rev. C. H. Rice, Rector of Cheam, to Evelyn Grace, youngest daughter of Edward Stenning, of Glenlyon, Beckenham.

SCOTT-FOSTER.—RUMBOLD.—On June 23rd, at Southsea, Tom Scott-Foster, L.D.S. Eng., son of Alderman Scott-Foster, L.D.S., J.P., to Olive Kate, only daughter of Mrs. Rumbold, of Southsea.

Deaths.

FLOYER—On July 12th, at Cotswold House, Egham, Surrey, Charles Anthony Floyer, M.D., aged 84 years.

GWYNN.—On July 1st, at St. Mary's House, Whitchurch, Salop, Samuel Tayleur Gwynn, M.D., aged 82 years.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

WITH a regret poignant in the extreme, Guy's men the whole world over received the news, last week, of the death of Sir Thomas Stevenson. Our distinguished and much-respected Lecturer in Forensic Medicine passed away on the evening of the 27th ult., at his residence in Streatham. His health had been not of the best for some time; never, in fact, since the sad death of Lady Stevenson; but it was not until the Sunday that his condition was at all serious. The cause of death was heart failure.

BORN at Rainton, in Yorkshire, on April 14th, 1838, he was privately educated. Entering Guy's Hospital about 1859, he qualified in 1862, and in 1864 he took his M.D. degree at London University, being University Scholar in Forensic Medicine and in Obstetrics. In 1870 he was appointed Lecturer in Chemistry, and retained that post for many years. He became F.R.C.P. in 1871, and in 1878 added to his other duties those of Lecturer in Forensic Medicine. In 1881 he was appointed senior scientific analyst to the Home Office, and in 1904 he was knighted. At different times he served as President of the Society of Medical Officers of Health, of the Society of Public Analysts, and of the Institute of Chemistry. He was the author of a "Treatise on Alcohol," and of various professional papers, and he edited, in 1883, the third edition of Taylor's "Principles and Practice of Medical Jurisprudence," and in 1892–94, with Sir Shirley Murphy, a "Treatise on Hygiene and Public Health," to which he contributed a monograph on water. In his official capacity he took part in most of the notorious trials for murder by poisoning which have been held during the last quarter of a century. Perhaps the case in which he first attracted public attention was that of Mrs. Maybrick, in 1889, and among subsequent ones may be mentioned those of Thomas Neill, or Cream (1892), Walter Horsford (1898), and Edward Bell (1899), all by strychnine, and also those of Mary Ansell (1899), Severino Klosowski, or Chapman (1903), in which antimony was employed, and Arthur Devereux (1905). It will be remembered that he was one of those present at the opening of the Druce grave in Highgate cemetery at the end of last December.

HIS death removes from amongst us not only a very prominent and distinguished member of the profession, but one who has shed for many years past much lustre upon our Medical

School. Since 1862 he had seen vast changes in the Hospital and School. A disciple of Swaine, Taylor and Odling, he has carried high, for many years past, the torch of forensic medicine and chemistry amongst us, and there must be many Guy's men who would acknowledge that these "dryish" subjects have been presented to him in a more pleasant light by the activities in lecture and experiment of our late professor. A somewhat reserved manner covered a very warm heart, and to those whom he admitted to his intimacy he was an excellent companion and friend. In private life he took great interest in church work in South London, and was most highly respected by all with whom he came in contact. Holding several influential public appointments, he was brought in touch with officials of every degree, and his courtesy and high breeding enabled him to carry out his onerous duties without friction or dispute. His family have our sincere sympathy in their bereavement, while we at Guy's mourn another good man and true who has thus passed from amongst us.

On another page will be found a few reminiscences from the pen of Mr. R. Bodmer, a gentleman who for many years was associated with Sir Thomas in his work. A full account of the cases with which the great expert had to deal, would, indeed, have made interesting reading. It is only four brief weeks ago that we personally approached Sir Thomas, and asked if he would jot a few of his experiences down for the Gazette. We knew he had been approached many a time, and his well-founded plea of "so much on hand now," had deterred us from asking him before. Nevertheless, on this particular day, he looked so well, and, if possible, not quite so busy, that we ventured. He replied that he would be delighted, as long as we could rescue them from the hands of the Editors of the Reports, who had also been keen to have them. This we promised to do to the best of our ability. On several occasions since then have we seen him, and each time have been struck with what we thought his much-improved appearance. Therefore, the sad news last Monday week came to us, as it must have to many, as a very great shock.

The Seventy-sixth Annual Meeting of the British Medical Association, held at Sheffield last week, was a conspicuous success. The Presidential Address, delivered by Mr. Simeon Snell, was very comprehensive, dealing as it did with the history and development of the Association, both local and general, Sheffield's share in the advancement of medical knowledge, and an account of miner's nystagmus. The personal note expected of these occasions was forthcoming in the work which the President had done on this "Industrial" disorder. The Address in Medicine, given by Dr. Kingston Fowler, was a thoughtful paper on the subject of Modern Medicine. His words on the advance which vaccine-therapy is making are those of a judicious but open-minded thinker, and we recommend them to those conservatives who fight shy of anything new.

Dr. Fowler's views on Medical Education are of exceptional interest, for he is Dean of the Faculty of Medicine at the University of London. Following on a recent law case, it is only natural that pessimism should mark his utterances as regards education in London. He envies those cities whose citizens are princely loyal, and prophecies that, in spite of all, the day will come when every medico must be University trained by an Institute, which will be efficiently endowed and have a status worthy of its great work. In other words, "centralization" must come. His remarks on the status of the practitioner of the future we recommend to our readers.

The Address in Surgery was delivered by an old Guy's man, Prof. R. J. Pye-Smith. It was a masterful address, with the keynote, Prophylaxis. In turn, the various departments of Surgery were reviewed, and the scope for prophylactic measures shown in each. The speaker did not forget to sound a warning, so often neglected by medical men, to wit, that though they guard the health of the community they are careless of their own, and he advises, wherever

possible, a weekly rest and a yearly holiday. To surgeons, he remarks, these are essentials.

We congratulate Dr. T. G. Stevens on his appointment as Physician to the Out-patient Department of the Queen Charlotte Hospital for Women.

We publish in this issue another letter from "A Roving Guy's Man," Mr. C. L. Leipoldt. He is at present at Graz, in Austria, from where we have also received some notes. He intends to do some Alpine climbing this month, then he goes on to Rome, to "do" the hospitals of the Eternal City. He expects to return to London about the middle of next month. His trip, judging from his letters, has indeed been a strenuous one, and he seems to have made the most of his opportunities.

An interesting publication to hand is the Year Book of Livingstone College, Leyton, E. The aims and objects of this Institution are to teach missionaries how to care for their own health, and how to deal with the more simple diseases of the natives in those parts far removed from properly qualified medical assistance. One sees from the letters received from various parts of the globe, this elementary knowledge has been of great benefit. Enclosed with the Report is an address by Sir Patrick Manson, delivered on Commemoration Day at the College. It is a short account, in simple language, of the advance in knowledge of tropical medicine, and when such a distinguished observer as Sir Patrick views the work of the College with favour, one may rest assured that the project is worthy of support by those whose philanthropy takes this special trend.

We congratulate Mr. E. L. Martyn Lobb on carrying off the Beaney Prize in Pathology; he certainly has taken a big share of the prizes this year, and success of this sort augurs well for his future career.

The Annual Report issued by E. Merck gives, in a concise form, the recent advances in Pharmaceutical Chemistry and Therapeutics, and anyone desiring to look up the literature of a new drug will find it of service. The little book can be found in the College Library.

"Of course, the Gazette must feel the silly season?" asks a correspondent. Well, even if we don't, I suppose we must say we do; it seems topically journalistic to do so. He has suggested many subjects for discussion, a list which is as variegated as it is typically silly. He commences with "Stiggins & Co.," evidently having in mind the prattling inanities of some of the lay press anent the statues on the new Strand building. His next heading is "Do Nurses flirt?" Readers, one and all, please understand we do not invite correspondence on this subject. As well cut the thread which held the sword of Damocles. Then his next, "Have Cocci Souls?" brings us into the realms of Psyche and Dr. Eyre. "Should the Residents be paid?" "Is Externing Exotic?" and "Was the Argyll Robertson Pupil a Scotchman?" are other examples of his suggestions.

Papers by Guy's Men.

The Treatment of Maniacal Chorea. By T. Churton, M.D.—*British Medical Journal*, 25th July, 1908.

The Effect upon the Staphylo-Opsonin Index Produced by the Oral Administration of Yeast Fat. By J. W. H. Eyre, M.D., M.S. Durh., D.P.H. Cantab.—*Folia Therapeutica*, July, 1908.

Some Out-patient Notes and Sketches. By Theodore Fisher, M.D. Lond., F.R.C.P. Lond.—*Clinical Journal*, 29th July, 1908.

The Diagnosis of Diseases of the Stomach and Intestines by X-Rays. By C. J. Morton, M.D. Edin.—*British Medical Journal*, July 25th, 1908.

A Case of Successful Removal of a Stone weighing Two Pounds. By Owen Richards, M.A., M.D., M.Ch. Oxon., F.R.C.S. Eng.—*The Lancet*.

A Clinical Lecture on Cox Valga. By A. H. Tubby, M.S. Lond., F.R.C.S. Eng. (Illustrated.)—*British Medical Journal*, July 25th, 1908.

Address in Surgery on Prophylaxis in Surgery, at the Seventy-sixth Annual Meeting of the British Medical Association, held at Sheffield, July, 1908. By R. J. Pye-Smith, Ch.M. Sheffield, F.R.C.S. Eng.—*British Medical Journal*, 1st August, 1908.

Treatment of Trachoma. By Arthur W. Ormond, F.R.C.S.—*The Practitioner*, August, 1908.

The Symptoms and Condition of the Blood in Pernicious Anæmia. By J. George Taylor, M.A., M.D. Cantab., M.R.C.P. Lond.—*The Practitioner*, August, 1908.

Some Personal Reminiscences of the late Sir Thomas Stevenson.

HAVING been for over fifteen years the chief assistant in the laboratory of the late Sir Thomas Stevenson—from about 1882 to 1897—and also having since then had the privilege of working with him in several recent medico-legal cases, I have been asked to furnish some personal reminiscences of that great expert.

The first case of any note that I can recall is the celebrated Lamson case. So much has already been written about this trial, that I must refrain from recapitulating all the circumstances connected with it. A few incidents, however, might be of interest, and they are as fresh in my memory as if they had occurred yesterday.

The articles which Dr. Stevenson and Dr. Dupré (who was acting with him) had to examine were some pills, powders, and the viscera of the deceased lad, Percy Malcolm John.

It was noted that one or two of the quinine powders were of a slightly buff tint, instead of pure white. On cautiously testing one of these powders, a very marked tingling sensation (which lasted for hours) was left on the tongue.

A pinch of the powder was introduced under the skin of a frog, and in less than ten minutes the frog was dead. I well remember the remark made by Dr. Dupré—"It must be a very powerful poison to kill a frog in ten minutes."

At that time Dr. Stevenson had no licence to employ physiological tests on animals, and as the chemical tests for aconitine (the poison which was suspected) are useless, Dr. Stevenson almost decided to go over to Boulogne to perform his experiments. However, as Mr. Golding-Bird had a licence, and placed his laboratory at his disposal, this course was not necessary.

The purified extract from the stomach contents of the poisoned lad was employed. The same tingling sensation was noted on tasting this extract as was produced by the quinine powders and by one of the pills, and a number of mice were injected with varying amounts of the extract—in every case with fatal results. The symptoms exhibited by the mice were exactly the same as those produced by injecting a solution of pure aconitine—of which one two-thousandth of a grain killed a large mouse in two minutes.

The accused (Dr. Lamson) was defended by the late Mr. Montague Williams and Dr. Tidy, who, however, did not appear in the witness box.

I recollect on the day on which Sir Thomas gave his evidence, during the adjournment for luncheon, Dr. Tidy remarked to him, "We are going to get the whole of the process of your analysis out of you."

Sure enough, Sir Thomas was requested to describe to the minutest detail the process which he and Dr. Dupré had employed in extracting the alkaloid from the viscera, and the subsequent experiments on the mice. Not a single step in the process was in any way criticised by Dr. Tidy, nor could Mr. Montague Williams in any way shake the evidence of Dr. Stevenson. The eminent counsel commented on the sufferings of the poor innocent mice, but did not, of course, refer to the agonies of the murdered lad. Lamson confessed his crime before his execution.

Another case of great interest, which, I think, is not so well remembered as the Lamson case, is that of a young Jew, named Lipski, who murdered a young woman by pouring nitric acid down her throat. I remember accompanying Dr. Stevenson to a little bedroom in a Whitechapel lodging-house, and chipping some bits off the floor boards, which were stained with acid. In his defence, Lipski accused two other men of having committed the crime, and of attempting to murder him (he was found under the bed of the deceased woman in a semi-conscious condition).

The two men were brought to Dr. Stevenson's laboratory to have their garments examined for acid stains—as they had only the clothes they stood up in—but not a single acid stain could be found. Lipski was convicted, and condemned to death.

Owing to the efforts of a certain newspaper

editor, who persistently maintained that Lipski was innocent, the execution was postponed for further inquiry.

The coat worn by Lipski, and much stained with acid, was submitted to Dr. Stevenson for examination.

The acid stains proved to be produced by a mixture of nitric and sulphuric acids, and I omitted to mention that the stains on the floor boards in the murdered woman's bedroom also reacted for both these acids. The police next took samples of nitric acid from every chemist's shop in Whitechapel. In only one case was sulphuric acid present, and that was from the shop at which Lipski was in the habit of buying the acid he used in his trade of a stick maker.

He was executed, having made a full confession at the last.

The case of Severino Klosovski (or Chapman) was one of great interest, owing to the two exhumations which were made. It is, however, no doubt well remembered by our readers, and I will only mention that the exhumed body of one of the victims was so saturated with antimony that a piece of the muscle of the thigh actually gave a distinct reaction for antimony by Reinch's test.

The last murder case that Sir Thomas was engaged in elucidating was that of Richard Brinckley. It was a very straightforward case, as the defence did not dispute the fact that prussic acid was found in the bodies of the victims, and Sir Thomas was not cross-examined. I might mention several other cases of interest, but do not wish to trespass unduly on your space.

Sir Thomas Stevenson was absolutely unrivalled as a medical expert, and also as a witness. Always calm and collected, he never allowed the opposing barrister to confuse him, and, at the same time, he never attempted to "score" off counsel, as many witnesses are prone to do. I doubt if we shall ever have such another medical and chemical expert—for he was unrivalled in both directions.

As a man he was a true gentleman, kind and courteous, and all those who had the privilege of knowing him will deeply feel his loss.

R. B.

Obituary.

T. H. B. Dobson,
M.D. Lond.

[We regret the delay which has occurred in compiling this notice, but we know that many of the late Dr. Dobson's friends will be pleased to see that we have enlarged upon the brief note which appeared in "Passim" shortly after his death.—Ed.]

By the death of Dr. Dobson, Guy's has lost one who, among the men of recent time, held a very prominent place.

Before coming to Guy's he was educated at Sedburgh and Owens College. He took no trouble to make a display of his talents, and consequently his work did not at first attract attention. His merits, however, were fully recognised later. His steady, conscientious work was rewarded by a series of appointments leading up to H.-P. It remained for the men of his time to pay their tribute to his worth. His personal charm won for him his election as President of the Residents. A quiet reserved man, straightforward in everything that he did, true to his friends, he filled an honoured post with dignity and credit.

Having taken his M.D. degree, he settled at Windermere, his native place. There he had great opportunities for the use of his many talents. His professional worth was bound to be known in any place in which he practised, and in a few years he made a large reputation. Although devoted to his profession, he had many other interests. His keen love of art in all its forms was well known. He arranged lectures, tried to foster a love of the beautiful in a lads' club, and gave unstinting work in parish and church affairs. Those who knew him intimately will recognise how useful a taste in poetry, painting and architecture such as he had would be to him in this work.

Early in the year he had an attack of pleurisy, and when this recurred the gravity of his condition became apparent. A succession of violent headaches only heralded the onset of meningitis, from which he died.

Of his life, ended at the age of thirty-one, he made the best use, but that which he did was only an earnest of what he could have done.

Preparation Received.

Messrs. Burroughs, Wellcome & Co. have forwarded us a sample of "Vaparole" Aromatic Ammonia. This s a convenient form of obtaining ammonia vapour in cases of fainting, etc. Done up in a capsule, surrounded by an absorbent material and covered with silk, the small phial can be easily and safely broken between the fingers. Its strength is undeniable, and its convenience far greater than "smelling salts." It is neatly put up in aluminised boxes of 12.

Pass List.

UNIVERSITY OF LONDON, July, 1908.—M.D. EXAMINATION. BRANCH I.—Medicine: H. F. Vandermin obtained the number of marks qualifying for the Gold Medal. BRANCH II.—Pathology: R. W. Allen. BRANCH IV.—Midwifery and Diseases of Women: E. G. Goldie, D. L. Morgan, E. W. Strange.

INTERMEDIATE EXAMINATION IN MEDICINE.—G. A. Blake, F. Cook, A. H. Gool, C. D. Killpack, G. T. Mullally, E. G. Schlesinger, *A. H. Todd, A. D. Vazquez.

* Distinguished in Physiology.

UNIVERSITY OF DURHAM, July, 1908.—Third Examination for Degree of Bachelor of Medicine: W. Reynolds. Second Examination for Degree of Bachelor of Medicine—Anatomy, Physiology, and Materia Medica: H. L. James. First Examination for Degree of Bachelor of Medicine—Chemistry and Physics: H. G. Dodd.

FINAL CONJOINT EXAMINATION, July, 1908.—Medicine, Surgery and Midwifery: *H. Chapple, *W. Johnson, *H. B. Kent, *V. Townrow. Medicine and Surgery: *H. O. Brookhouse, *H. B. Carter, *L. T. Dean, *K. H. Hole, *C. C. Holman, *H. I. Janmahomed, R. A. Rankine, D. Reynolds. Surgery and Midwifery: J. R. Perdrau, C. M. Plumptre. Medicine only: F. R. L. Atkins, M. E. Ball, C. A. Basker, S. J. Darke, *J. B. Dunning, H. N. Greaves, *P. C. Higgins, D. Isaacs, A. E. Lees, E. R. Stone, W. E. Wallis. Surgery only: P. A. S. Dyson, *R. Franklin, J. W. Grice, *F. W. Hogarth, H. Lee, R. P. M. Roberts, C. A. Wood. Midwifery only: D. Allan, S. S. Brook, T. F. Brown, E. P. L. Hughes, H. C. Lucey, E. L. W. Mandel.

* Denotes completion of Examination.

SECOND CONJOINT EXAMINATION—E. Billing, H. G. B. Blackman, F. B. Bull, L. C. W. Cane, N. S. Carruthers, H. H. Davis, J. A. Delmege, A. L. Gardner, R. Heaton, G. C. Lowe, G. L. Preston, T. S. Sharpley, B. T. Verver, W. P. Vicary, M. C. Wall, O. E. Williams.

FIRST CONJOINT EXAMINATION.—Chemistry, Physics and Elementary Biology: C. G. McClymont, G. Noott. Chemistry and Physics: †F. S. Glover, †H. Harrison, †A. S. Morgan, †F. W. Paul, †C. F. Snow, †D. Wain, S. Wickenden. Chemistry and Elementary Biology: G. A. Pratt, A. K. Selim. Physics and Elementary Biology: H. C. Godding. Chemistry only: A. B. Danby, W. C. Whitworth. Physics only: H. D. Shore, †W. S. Stranack, †E. O. Yerbury. Elementary Biology only: E. R. Bailey, R. B. Campion, H. S. Groves, K. J. T. Keer, R. H. Lucas, H. L. Messenger. Practical Pharmacy: T. S. Allen, F. S. D. Berry, L. P. Harris, E. R. Hart, H. R. Mullins, G. B. Pritchard.

† Preliminary Scientific (L.D.S.) Examination.

Dental News.

Men of all entries will regret that Mr. Spiller is leaving us this term. He has been not only a good teacher, but also one to whom many of us owe much in the treatment of refractory teeth, and in other ways. We shall all regret his loss.

To-day (August 8th) the Dental Department closes until the end of the month. During this time considerable alterations will take place.

The downstairs laboratory will in future be used by the senior men, while the pupils will move into the large one upstairs, which will be altered to suit their requirements. The growth of the pupils' department has been most satisfactory, and it is evident that increasing numbers of men will continue to take their training in mechanics in the hospital.

This is to their advantage in every way. The hospital appliances are more up to date, and the best methods are to be learnt here. Present Guy's students, while on their holidays, should be active recruiting agents for their hospital.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated.*

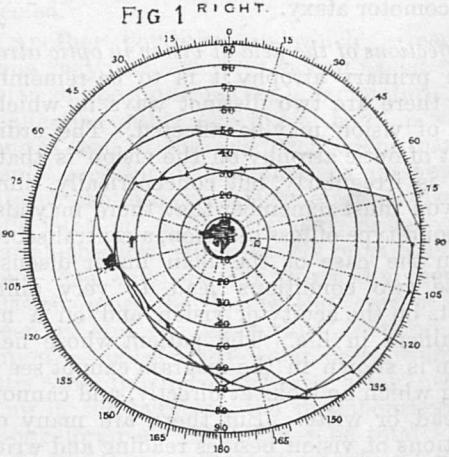
A Case of Partial Optic Atrophy.

CLINICAL LECTURE BY Mr. H. L. EASON.

Gentlemen,—The case which will be the subject of to-day's lecture is that of a man who has been in the surgical and medical wards on several occasions, and I will commence by reading you the history of his case, as compiled by my ward clerk, Mr. C. A. Wood. He is a man, æt. 26, and in 1901 was employed at the docks as a stevedore. Working one night, in charge of a donkey engine, which was unloading a cargo, he had to watch the movements of the hands of a second man, looking over the hatchway, who was standing beneath an uncovered arc light, for the signal to raise or lower the crane. He had to keep his eyes on the man's hands and the light during the whole night, and in the morning could hardly see at all, so great was the effect on his vision. He is certain that he could read a newspaper quite easily up to the date of this occurrence. He had been a heavy smoker, consuming, on the average, one ounce of shag a day, In 1906, he fell down in the street, and was run over by a tram, sustaining a compound fracture of the tibia and fibula on the left side. For this injury he was admitted into Cornelius Ward, where I was asked to examine his eyes, the condition of which was much the same as it is to-day. In Cornelius, he suffered from bed sores and spasmodic jerkings of the legs, which were supposed to be due to the injury to his back. In March, 1907, he was admitted into Stephen Ward, under Sir Cooper Perry, for spastic paraplegia. He had then well-marked adductor spasm, and scissor-legged progression. Subsequently, in January of this year, he was readmitted into the surgical wards, under Mr. Rowlands, when various tenotomies were performed, and his ability to walk was much improved as a result. He has recently been admitted to the Eye wards for his ocular defect.

Present condition.—When the patient's eyes were examined, it was found that the vision in each eye was less than 6/60; that is to say, he could not read any of the ordinary types on our test-boards at the usual distance. So his vision is useless for any fine work, such as reading or writing, and he cannot count fingers held up comparatively close to him. He fixes eccentrically with each eye, so that, when he tries to see an object, his eyes are apparently directed upwards, his fixation point being above the real yellow spot. His pupils react to light, but not briskly, and with distinct hippus after the primary contraction; this is especially marked on the right side. Both discs are whiter than usual, especially at the outer side; edges well defined and clear, and vessels of normal size. There is no obvious patch of choroiditis, or any other inflammatory or congenital lesion at the macula. The field of vision is the interesting point about his case, and is shown in the diagram (1). It is taken with the ordinary

FIG 1 RIGHT.



perimeter, and a note is made that he has deep-seated eyes and well-marked eyebrows, which account for the upper part of the field being deficient. Otherwise, the limits of his field of vision are practically unaltered. In the centre of the field, however, at the fixation point, there is a loss of vision, called a central scotoma. If his eyes are fixed so as to be apparently looking at an object, he cannot see it. He manages to look at a thing by tilting his eye up, so that he sees round this central defect, and, if he were roughly tested in the ordinary way, by means of types and reading, it would be said that his vision was very bad indeed. But when one comes to analyse his visual defect, it is found not to be as serious as might have been thought, for, except for the central defect, all the rest of the field of vision is normal, both for white and for colours. The condition is one of *partial optic atrophy, with a central scotoma.*

Optic Atrophy.—Only a bare mention need be made of the differential diagnosis of primary and secondary atrophy of the optic nerve; that is taught every day in the medical wards. You know that, in the ordinary primary atrophy, the disc is white, or bluish-white. It is sharply defined, slightly hollowed out, looking rather

like a saucer, from atrophy of nerve fibres; the lamina cribrosa is very well marked, and the retinal vessels are normal in size. This is the case with this patient. The sight is much reduced in most cases of primary optic atrophy, the defect eventually proceeding to complete blindness. Inflammatory or post-neurotic atrophy, which is not so much an atrophy of the nerve as a fibrosis of the optic disc, following an inflammatory exudate, is outside the limits of this discussion, which is confined to optic atrophy, such as is met with typically in cases of locomotor ataxy.

Affections of the field of vision in optic atrophy.—In primary atrophy it is to be remembered that there are two distinct ways in which the field of vision may be affected. The ordinary effect of optic atrophy on the vision is that the field is irregularly, but concentrically, limited; but you must remember that there may also be a second type of loss of vision, a central scotoma, as in the case of the man under discussion. These two conditions lead to very different effects on the acuity of vision and on a man's usefulness in life. The patient whose field of vision is shown in the diagram cannot see anything which he looks at directly, and cannot see to read or write. But there are many other functions of vision besides reading and writing; when you walk along the street you do not look directly at the pavement to see where to place your feet, and you do not consciously look to see if an omnibus coming from the side is likely to collide with you. That is all done automatically by means of the peripheral part of the retina, and this consideration may emphasize the difference between direct and indirect vision. Direct vision is the act of looking straight at an object so that its image falls on the macula. This area of distinct vision is very limited in extent, being represented by an area in the field about the size of a thumb-nail held at arm's length. All the rest of the retinal image is more or less blurred and indistinct. This is not noticed in the ordinary way, because the eyes are continually being moved, and only about one-tenth of a second is occupied in getting an accurate mental impression of what is being looked at. If a man, therefore, has lost his acute direct vision, but retains his indirect vision, he can see well enough to walk about, as he does not knock up against people, and he may be able to work as an ordinary labourer, though not as an engraver or clerk. On the other hand, the ordinary patient with locomotor ataxy and optic atrophy may have very good direct or central vision, and probably can still see to read and write, but his field is very small and contracted, and, owing to the loss of his indirect peripheral vision, he has great difficulty in walking about without assistance, and is comparatively helpless.

The function of the rods and cones.—The consideration of those two defects of vision leads one to say a few words about a rather more complicated subject, but a very interesting one, viz., the dual function of the rods and cones in the retina. You also know, as an anatomical fact, that at the yellow spot there are cones only, and no rods. It is also known that, in the periphery of the retina, the rods are much more numerous than the cones, and that in nocturnal animals, such as bats, there are very few cones, nearly all rods. Von Knies, whose paper was quoted and amplified by Mr. Breuer, in Vol. XVIII. of the Ophthalmological Society's Transactions, proposed a theory as to the functions of the rods and cones, which must be considered in relation to the two types of vision—central, and indirect. The cones are all thickly crowded together at the yellow spot, and the yellow spot is that part of the retina which is used for fixing an object. That is to say, with the cones there is very acute vision for small objects in the centre of the field of vision. The vision for colour also is most acute immediately at the central fixation point, and is very defective in the peripheral part of the field, corresponding to the distribution of the cones. The cones receive the best impressions, and pass on the best stimuli to the brain in very bright lights; but they are comparatively inefficient in dull lights, and in observing small movements which are more easily observed by the peripheral parts of the retina than the yellow spot. It has been long recognised that everyone has a central scotoma, or relative failure of vision, in the centre of his visual field in very low lights, for astronomers have found that the fainter stars can be counted better if they are not looked at directly. If you try to count the number of stars in the constellation of the Pleiades by looking directly at them, you cannot; but by looking a little above, or below, or to the right, or to the left, you can easily see that there are six larger stars in the group. On a dark night you can see a thing better if you do not look directly at it, as is very evident in picking one's way along a dark lane. In minimal illumination, therefore, everyone has a central scotoma, the rods in the periphery being the more efficient in very poor light. The functions of the rods

and cones, therefore, may be summarized as follows:—

The Cones—

1. Are the organs of acute vision for small objects.
2. Are the organs for perception of colour.
3. Attain their maximum efficiency in bright lights.
4. Are comparatively inefficient for observing small movements.

The Rods—

1. Attain their maximum efficiency in minimal illumination.
2. Do not take part in the perception of colours.
3. Are sensitive to small movements of objects in the periphery of the field of vision.

After these preliminary remarks, the conditions in which there may be a central scotoma may now be considered:—

1. It is obvious that if anything injures the cones in the retina there will be a central scotoma. The commonest cause of such an injury of cones is *prolonged observation of bright lights;* for example, the sun, or an arc lamp. When there is a solar eclipse, it is common for careless people to look at the sun without using smoked glasses, and as a consequence to develop a scotoma lasting several months.

2. Another common cause of a central scotoma is tobacco. The usual symptoms of tobacco amblyopia are inability to read or write, loss of the power of distinguishing colours, as, for example, the difference between a sixpence and a half-sovereign. Vision is better in a dull light, and the patient has a central scotoma for red and green, and in several cases for white as well. Tobacco amblyopia is caused by excessive smoking, more particularly of shag in clay pipes; cigars and cigarettes are not such frequent causes, unless the smoking is carried to great excess, and it is supposed that the condition is due to the paralysis of the cones by some constituent of tobacco. At any rate, the symptoms of the disease are exactly in accord with those that might be premised on the theoretical grounds cited above.

3. Other causes are not retinal affections, but *partial atrophies* or *affections* of *the optic nerve* occurring in *general nervous disease* or *intracranial lesions*. Of these, by far the most important is *disseminate sclerosis*. In this disease there is often a partial optic atrophy with central scotoma, and the condition is so characteristic as to form one of the diagnostic phenomena of the disease. The classic monograph on the subject is that by Professor Uhthoff, of Breslau, who, in 1889, published a paper entitled "Untersuchungen über die bei der multiplen Herdsklerose vorkommenden Augenstörungen." According to Uhthoff's figures, over 50 per cent. of all cases of disseminated sclerosis suffer from affections of the eye, and in about 50 per cent. of these—or 25 per cent. of the whole—the visual defect takes the form of a central scotoma, the periphery of the field remaining comparatively unaffected.

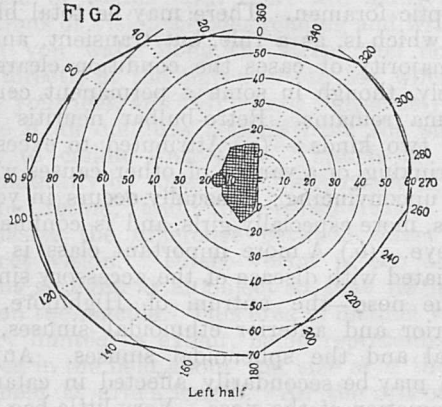
4. Another condition in which a central scotoma may occur is *retro-bulbar neuritis*, an affection of the optic nerve, inflammatory as a rule, affecting either one eye or both, in which nothing is seen in the eye itself. The patient suddenly goes blind, and there is no obvious neuritis at the disc or evidence of other disease, though later on a neuritis may or may not appear at the disc, subsequently progressing to atrophy. As only one eye is usually affected, the lesion must be below the chiasm and between it and the globe, and therefore the condition is called retro-ocular or retro-bulbar neuritis, the inflammatory area being usually high up in the nerve in the neighbourhood of the optic foramen. There may be total blindness, which is, as a rule, but transient, and in the majority of cases the condition clears up entirely, though in some a permanent central scotoma remains. Retro-bulbar neuritis may be of two kinds:—(*a.*) Attributed to excessive tea-drinking, or a variety of other causes which seem unconvincing; it usually occurs in young adults, more especially girls, and is confined to one eye. (*b.*) A more important class is that associated with disease of the accessory sinuses of the nose—the antrum of Highmore, the posterior and anterior ethmoidal sinuses, the frontal and the sphenoidal sinuses. Any of these may be secondarily affected in catarrhal inflammation of the nose. Very little has been written on the subject as yet, but Professor Onodi, of Buda-Pesth, has recently published a monograph, containing some admirable pictures and much excellent information. Some of the illustrations show in a very striking way the relation between the optic nerve and those bony sinuses. Professor Onodi describes cases of sudden loss of vision associated with purulent dilatation of the bony sinuses, and the ordinary history is that of neuralgic pain on one side, which becomes intense, accompanied by failure of vision on the same side; there is a discharge of blood or pus from one nostril, the pain is

relieved, and the vision returns. The frontal sinus is not so intimately connected with the optic nerve as are the anterior and posterior ethmoidal sinuses, but it is occasionally associated with retro-bulbar neuritis.

5. There is a rare but distinct variety of optic atrophy, associated with central loss of vision, which is usually hereditary, transmitted through the females, but only affecting the males; this is *Leber's, or hereditary optic atrophy.* It commences, as a rule, about puberty, progresses to a certain extent, and then stops; it seldom leads to total blindness. The loss of vision is, as a rule, in the form of an absolute central scotoma, the peripheral field being unaffected. The condition is usually associated with malformation of the sphenoid bone.

6. Another class of causes of central scotoma is that of *lesions of the optic chiasm.* They are not very common, and are usually in the nature of a gummatous meningitis, or a tumour of the pituitary body. From Norris and Oliver's textbook of Diseases of the Eye has been taken a chart of the field of vision of a patient who was suffering from tumour of the pituitary body (Diagram 2). The patient suffered from bitemporal hemianopia when the condition was

FIG 2

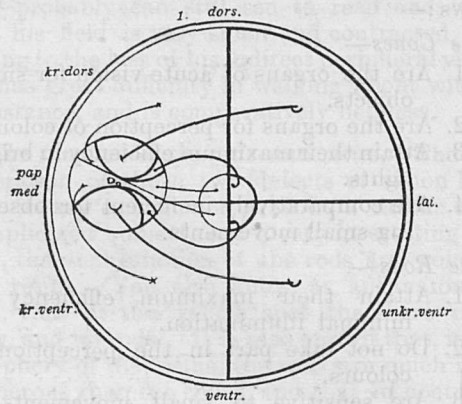


Left half

acute, but the symptoms were relieved, and what remained was a permanent central scotoma at the commencement, proceeding later to a complete bitemporal hemianopia.

Appearance of the optic disc.—What is the usual appearance of the optic disc in these cases of central scotoma? To properly appreciate this, it is necessary to know something about the course of the fibres of the optic nerve. For this purpose, I have extracted from Norris and Oliver's book a few sections showing the path of the nerve fibres. Diagram 3 is one of the retina and optic disc. In the middle of it is the

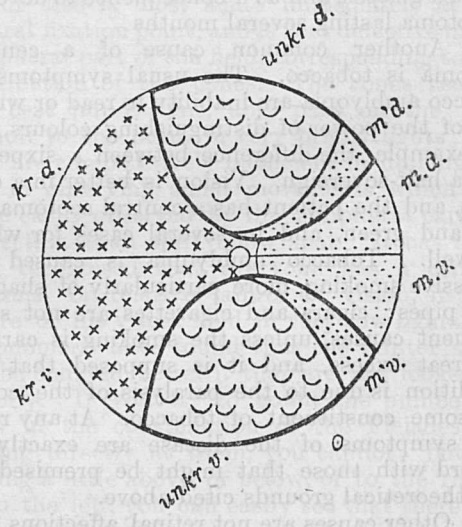
FIG 3



Subdivision of nerve-fibres in the retina.

yellow spot. Remember that the macula, the yellow spot, and its nerve fibres, are the things affected in central scotoma. You will see that the greater part of the outer half of the optic disc is composed of fibres from the macular region. All the rest of the fibres from the retina go into the other parts of the nerve. On cutting a section of the optic nerve, just behind the disc (Diagram 4), the macular fibres are

FIG. 4

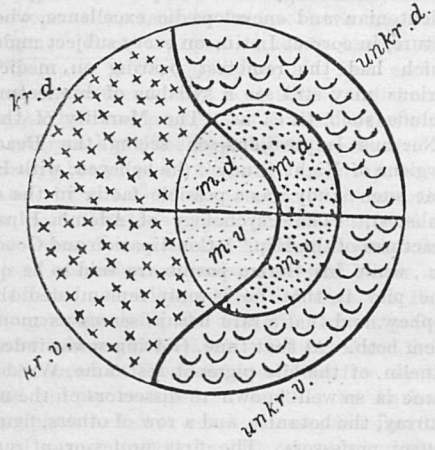


Subdivision of nerve-fibres in the optic nerve.

shown again, in a roughly triangular distribution, on the outer side of the nerve. Further back in the nerve they occupy a more central position, and further back still they have all got into the centre, and form the axial fibres of the optic

nerve (Diagram 5). Therefore it is to be remembered that the most important fibres for central

FIG. 5



Subdivision of nerve-fibres in the optic nerve.

vision are those which are contained in the outer side of the disc.

It is easily understood, therefore, that in cases of central scotoma, with an otherwise unaffected field of vision, there is usually atrophy of the outer side of the optic disc. Such was the condition in the eyes of the man who is the subject of to-day's lecture, and it is nearly invariably so in all partial atrophies of this class.

It remains now, having considered the various conditions in which a central scotoma may occur, to make a diagnosis as to the probable cause of the defect in this man, who suffers from a spastic paraplegia, partial optic atrophy, and a central scotoma.

Is his optic atrophy associated with general nervous disease, or is it something unconnected with his spastic paraplegia? In an ordinary spastic paraplegia the eyes are usually unaffected. The common conditions in which you find optic atrophy are, first of all, *locomotor ataxy*, where there is often primary optic atrophy of the classical type, and in which the vision may be very defective, with a concentric constriction of the field, and *disseminate sclerosis*, in which the visual loss is central, not peripheral, and associated with spastic paraplegia, nystagmus, intention tremors, and scanning speech. Therefore, a serious consideration in this case is, whether the patient might not have disseminate sclerosis. Then Friedrich's ataxy must also be considered; but in that disease there is usually no optic atrophy, so that, if the latter is present, the case is probably not one of Friedrich's ataxy. The point, therefore, to be decided is, whether this man has disseminate sclerosis, with a central scotoma and spastic paraplegia, or whether these two conditions are entirely unconnected. Beyond the spastic paraplegia and the central scotoma, the patient has no other symptoms of disseminate sclerosis, and the paraplegia seems to have very directly followed on accident, and it is probable that they are unconnected, for, according to the man's history, the tram accident was in 1906, and his eyes began to fail as far back as 1901. He had been a very heavy tobacco smoker—one ounce of shag a day, for years—and, therefore, the supposition is that the cones of his retina were so weakened with tobacco that the one night's exposure to the additional injury of looking continually at an unshaded arc lamp was sufficient to injure them irreparably.

The diagnosis, therefore, is that of optic atrophy due to excessive tobacco smoking and over exposure to electric light.

The prognosis in such a case is not good. It is practically hopeless to expect any improvement in vision after the lapse of such a long period since the injury; but, on the other hand, the condition is apparently stationary, and will not lead to total blindness.

Appointments.

Civil.

DENMAN, R., M.R.C.S. Eng., D.P.H. Camb., has been appointed Health Officer to the State of Perak, Federated Malay States.

FAGGE, R. H., L.R.C.P. Lond., M.R.C.S., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Melton Mowbray District of the County of Leicester.

SIMPSON, GRAHAM S., F.R.C.S. Eng., has been appointed Visiting Surgeon to the Sheffield Union Poor Law Hospital.

STAMP, W. D., M.R.C.S. Eng., L.R.C.P. and L.M. Edin., has been appointed Medical Officer to the Union Workhouse and Infirmary, No. 1 District, and Public Vaccinator to the Plympton St. Mary Union.

Naval.

Fleet Surgeon W. J. BEARBLOCK, R.N., has been appointed to the *Gibraltar* for charge on the voyage home.

Notes of a Roving Guy's Man.*

V.

To most GAZETTE readers, the sleepy hollow of Göttingen, that quiet little University town, with its hundred odd *studiosi medicinæ*, will probably be known only through its being the reputed home of sweet Matilda, the

"daughter of my tu-
Tor, law professor at the U-
niversity of Göttingen."

Few of us who do not know the affecting story of the love-sick law student! Göttingen, to English folk at least, has won universal fame through the lilting six-verse chantry that no one knows the author of. But the town is worth a visit from surgical students. Not because it is a surgical centre. You must not travel thither to see heroic operations, or to make voluminous notes, though, to be sure, there are good men there—Professors von Braun and Rosenbach in surgery, Professor Cramer in psychiatry and nervous diseases. Professor Hirsh in medicine, and Professor Ehrlich in pathology. If you wish to do post-graduate work in peace and quiet, by all means go there. You may hire a room, as comfortable as any at Honor Oak Park (once you have learned to understand the mechanism of those abominable "Berlin" stoves), for £5 *a term*, with £1 10s. extra for boots and breakfast; the coal you supply yourself, and your meals you may obtain at a students' restaurant for eightpence each upwards. Most of us make the mistake of going to large centres, instead of visiting places like Göttingen. To a certain extent the large centre is all very well. It may be excellent if, as in Berlin or Paris, there is a host of professors, enormous material, and plenty of opportunity; it may be very much the reverse, as at Munich or Leipzig, where the staff is comparatively small, and the clinical material far below the needs of the excessively large number of students who are walking the wards. The small University town is, in many ways, the ideal, especially for the student who wishes to do research, and not practical work, and, of the smaller centres, Göttingen is one of the best. It possesses a remarkably fine University library and a good pathological collection, while its hospital, though not large, is well directed, and quite sufficient for the needs of the clinic. A quiet little place, with "sets" in it, and all the etiquette of a stick-in-the-mud collegiate centre. I imagine they sweep their hats a little lower there when they meet the Privatdocent in the street, and that the feeling of reverence while in the presence of a herr professor is almost pathological. Certainly I have nowhere heard "Herr Geheimrat" uttered with so awestruck and respectful an intonation. And that notwithstanding that a Göttingen greathead made merry of the term, and asked, spitefully, "How does Geheimrat Hippocrates, or Oberhof-medicinahrat Galen sound, pray?"

As a University, Göttingen is not without its points of interest to surgical students, because it has figured pretty largely in the history of surgery. Somewhere here, in the cemetery behind the town, lies buried August Gottlob Richter, of hernia fame—no one knows his grave. His uncle, George Richter, the first professor of medicine at the University, was a many-sided old gentleman, of Crichtonian and encyclopædic excellence, who used to lecture, in correct Latin, on every subject under the sun which had the remotest bearing on medicine. The curious may still see a syllabus of his lectures, which include such titles as "The Morality of the Nude," "Nervous Impressions on seeing the Dead," "The Hygiene of Night Study" (he believed, with Boerhaave, that such study was a possible factor in the etiology of diabetes), "The Psychology of Adam's Blush," "On Fractures of the Hip," "Constipation and Good Health," etc., while his Syriac poems are said to be quite good. The pity is that he is only remembered through his nephew, and that a rare hernia serves as monument for them both. At that time, Göttingen was indeed famous. Ginelin, of the bile pigment test fame, Wrisberg, whose name is so well known to dissectors of the upper arm, Murray, the botanist, and a row of others, figured on the list of professors. The first professor of surgery was A. Haller, who for seventeen years lectured on a subject he knew only theoretically,* and lady students were admitted to and graduated at the University, as witness Miss Schlözer, who, in 1785, obtained her degree of Ph.D. The curious old rules of the institution are still extant, but not enforced any longer, just as the regulation ordering the payment of the equivalent of ten shillings to every farmer "who shall deliver up, alive or dead, the body of any cobold, fairy, or gnome caught among the cows," is no longer in force—probably because the Göttingen folk have given up the hunting of sprites for the chase of cocci and other "bugs." The equally curious prescriptions in use in Richter's time are no longer valid, for most chemists would have some difficulty (even those enthusiasts who win the weekly prizes offered by the *Pharmaceutical Journal* for the deciphering of hieroglyphs) in reading something as follows:—

℗ tr. p. ℈ xii.
ϴ H ac. cr. ℈ i.
∇ ~ ʒxxx. M. F.S.†

The whole history of the first half-century of the Göttingen school during the time of the Georges is extremely interesting, and to the surgical student the figure that dominates the picture is that of Richter. His papers, well written and clear, with details of cases and (what is specially valuable to English readers) an

* Series I., II., III. and IV. of Notes appeared in GAZETTE of April 4th, May 2nd, May 16th, and June 13th.

* "Etsi chirurgiciæ cathedra per septemdecim annos mihi concredita fuit, etsi in cadaveribus difficillimas administrationes chirurgicas frequenter ostendi, non tamen unquam vivum hominem incidere sustinui, ne nocere veritus"—as he confessed.

†These signs were merely trade or professional symbols to prevent the patient knowing what the prescription contained. The above simply means, in order, potassium nitrate, crude ammonium carbonate and water, the old sign for scruple being used. Some such system might with advantage be followed nowadays by those who prescribe proprietary drugs.

extraordinarily able summary of the work of Percival Pott, whose student he was, are still valuable. Those on herniæ, on bronchotomy, on carcinoma of the stomach, and on operations on the eye, are especially interesting, giving as they do such a clear review of what might be called the international surgical opinion of his day. His pupils were equally active, and many of our present-day operations may be said to have originated in Göttingen. Every surgical student knows that Charles White, in 1768, published his first case of resection of the humerus, but it is not so well known that, though White had proposed a similar operation in cases of inveterate hip disease, and had practised it on the dead body, his proposal was only taken up, half a century later, by the Göttingen school. Vermandois and Koeler, both Richter's pupils, published in 1786 the results of a series of resections of the femur which they had practised on living animals, and laid down the principles of the operation, which Schmatz, in 1816, successfully performed for the first time on a patient suffering from tubercular disease. Schmatz found, however, that the head of the bone was lying free in the capsule, and simply removed it, so that to Anthony White, who published four cases of resection in 1820, the credit of carrying out the full operation must in justice be given. So also, probably, was it the Göttingen school that popularised the use of plaster splints in cases of fracture. Plaster had been used in the treatment of fractures as early as the 13th century in Arabia, but its first introduction into European practice was at the end of the 18th century, when Consul Eaton, of Bassaro, wrote an account of the Arabian method to Dr. Guthrie, and the novelty was speedily taken up in Germany. Reading over Richter's remarks on scirrhus, I was struck with the essential similarity between the views he held on cancer and those which prevail to-day. Thus he held, with Halstead, that one ought to extirpate the breast wholly, "to prevent the cancer poison from infecting the body." Mr. Jacobson's terse remarks on this caution would not have had much weight with him, for he was acquainted with the fact that no such cancer poison had been demonstrated. Febure and Peyrilhe, in 1763, had proved that dogs fed for a long time on cancerous tissues remained in excellent health, and that it was impossible to transplant cancer into an animal, and the most that they could effect was, by rubbing "cancer juice" into fresh wounds made in dogs and wild cats, to produce what they were pleased to term "a malignant ulceration"—probably a secondary pyogenic infection. Nevertheless, Richter thought that a cancer poison might exist, and vigorously defended "early, radical, and universal extirpation," against the opinion of the elder Monro, who stated that out of 60 cases of mammary carcinoma operated upon, a "recurrence" was absolutely certain in at least 56. The Göttingen surgeon, it is worth while to note, taught that in every case the glands in the axilla ought to be removed—an opinion which, so far as I know, was supported first in England by Gooch, the surgeon whose name is eternally associated with the wooden "splits" splinting. Equally interesting were the opinions of the Göttingen school as to the treatment of aneurysm. The theoretical operation proposed by Brasdor, and first performed by Desault, was taken up by them, and even the "artery suture," which is coming into fashion again, was tried by them. In varicose veins they extirpated the veins or tied the saphena in the thigh (an operation first described by Everard Horne and now ascribed to Trendelenburg), and used Rowley's method as well as Baynton's, both forgotten in England to-day. It is time someone wrote the history of the Göttingen school, for even here Richter is remembered only by his hernia. His portrait hangs in the Langenbeck Haus, where the Surgical Congress met the other day, yet I doubt very much if a quarter of the members know as much about his work as they do about Astley Cooper or Desault, which only proves how little the prophet is remembered in his own country.

My short excursion to Göttingen was made at the commencement of the summer term, and on returning to Berlin I found work at the Clinic, which had been somewhat interrupted by the unusually dull Surgical Congress, during the sessions of which work was suspended and the assistants allowed a holiday, again in full swing. At the Congress itself the only communications in any way original were Prof. Trendelenburg's note on his new operation for pulmonary embolism after fractures, and Prof. Förster's two cases of Little's disease successfully treated by resection of the posterior roots in the lower dorsal and upper lumbar region, which roused the phlegmatic meeting to something like Gallic enthusiasm. The embolism operation is a somewhat more heroic procedure than Lauder Brunton's proposed section of the mitral valve in cases of stenosis. Essentially it consists in opening the right ventricle, removing the clot, and suturing the cut. The practical difficulties of such an operation need not be discussed here, but cardiac surgery has made such vast strides of late years that they are no longer regarded as insurmountable. In one case only has Prof. Trendelenburg tried his operation on the human subject. This was a woman with fracture of the neck of the femur, who was suddenly seized with lung symptoms, and on whom the operation was attempted while she was practically moribund. The patient died, and the Professor concludes that he was too slow—the operation ought to be done in less than a minute—and compressed the pulmonary vessels too long. An attempt on a calf succeeded gloriously; the animal survived the operation, and when killed four months later, the autopsy showed the wound had healed by scar tissue. Initiating, as this communication did, a discussion of the whole subject of embolism in surgical practice, it was certainly a most interesting and valuable contribution. Here I have heard it stated that "every practitioner ought to be as familiar with cardiotomy and cardiorrhaphy as he is with tracheotomy or kelotomy," and the operations are frequently practised on the dead subject. Rehn's method of pericardiotomy, for example, is a really simple and easy operation, and since 1900 it has replaced all the older methods, such as the 5th

cartilage, the epigastric or the direct sternal routes. A curved incision is made from the lower border of the 7th left rib, crossing the base of the ensiform cartilage, and being altogether about 6 c.m. long. The 7th left costal cartilage is cut through at its sternal junction with a pair of very thin, curved, sharp rib forceps (an excellent model with very good leverage). The internal mammary artery is not damaged, and it is easy to pass one's finger between the triangularis sterni and the sternal attachment of the diaphragm, feel for the inferior sterno-pericardial ligament, and follow this up, guarding the sac while the 7th costal cartilage and a small piece of sternum are cut away. This lays open the pericardial sac at its lowest point where it is uncovered by pleura, and where it can be very effectively drained. The Heidelberg experiments of Gottlieb have shown that the heart can be compressed for several minutes without endangering its vitality – a matter of supreme importance in controlling hæmorrhage—but the difficulties of suturing are still very great. Rehn himself, and Tuffier, in Paris, advise fine silk, and strongly condemn the use of catgut or silver wire. An interesting point in the differential diagnosis of cardiac wounds is the possibility of confounding the case with an intra-abdominal lesion. The main symptoms are the pain down the left arm and the extreme dyspnœa which results when pressure is made directly over the cardiac area. This latter symptom causes the patient to keep his left rectus muscle absolutely rigid, which in one case has led to a laparotomy, under the impression that the case was one of ruptured spleen.

More interesting, perhaps, because of its more practical possibilities, is the new operation for infantile spastic diplegia. The two cases demonstrated were certainly excellent so far as results went, but one prefers to wait for a while before accepting them as complete cures. The operation is said to be very difficult, and out of eleven attempts, two, those shown, only were successful in so far that the posterior roots were resected. Both children can walk by aid of a stick and slight help from an attendant, but Dr. Förster admitted that a great deal—a very great deal—depends on careful and persevering education in the after-treatment. Paralytic orthopædic cases are relatively common here, more so than with us, but the treatment does not appear to be much better when the ultimate results are compared. Plaster splinting is largely relied upon; tendon transplantation and larsectomy are only rarely done, although in one case I saw a tendon transplantation by Lange's method done for a case of acquired myogenic club foot.

An interesting case at the clinic last week was a child of six months with a paralytic club foot, which was diagnosed as due to poliomyelitis—certainly a very early case. The treatment was by splints and massage. A full history and notes of the case are taken with every patient, measurements being carefully recorded, and the clinic has a very large amount of valuable statistics for future reference. I have already described the treatment of tubercular joint lesions, and need only add that the "control criteria" for the progress of each case are: (1) weekly weighing and a record of the body weight; (2) estimation of mobility every day when the hyperæmic treatment is used, and (3) periodical X-ray photographs.

At the head of the Royal Surgical Clinic (of which the Orthopædic Clinic is merely a special department) stands Geheimrat Professor Bier, the originator of the hyperæmic method, and one of the foremost German surgeons. Daily, on week days, from eight to eleven in the morning, Bier operates in the large operating clinical room, which is larger than our old operating theatre, though arranged somewhat in a similar way. The operations are well attended, the auditorium being crowded every day with from 150 to 200 students. A patient is brought in, and the professor calls down one of the audience and allows him to examine the patient, questioning and lecturing while the examination is going on. This *viva voce* is not very severe, as the professor usually has the goodness to answer his own questions before the student has a chance to reply! Thus, in a case of exophthalmic goitre, the examination was really a monologue. "What do you make of it? Why, of course, it is a case of Basedow's struma. Do you think it small? Well, so it is; but it has given rise to dyspnœa. Why? Doubtless because there is a process, which goes backwards, and which is difficult to feel, compressing the trachea. How do the physicians treat it, eh? Come along, now—what iodides? Now, you can't be too cautious with your iodides; they often do far more harm than good. Electricity, palliatives—that's their method. No; every surgeon, nowadays, believes that such cases should be operated upon, and the sooner the better. The bad results to which the physicians point are due to the fact that operation is often deferred too long. What incision would you make? Of course, a transverse one; only in exceptional cases does one need a longitudinal incision in neck cases. What anæsthetic? Local; it does admirably, as you will see. Now, tell me, where would you inject your novocaine solution?"—and as the student hesitates, the professor helps him out. "Why, just remember your anatomy. Here you have the nodding muscle (sterno mastoid), and here is the vena jugularis externa. Where they cross, just in that neighbourhood, lie the nerves we are concerned with, superficiales colli, auricularis magnus, and supraclaviculares. You sink the point of your needle below the vena jugularis, so—my good woman, it is merely a prick—and inject. Then you must wait for twenty minutes or more, and you can proceed with the operation." The case goes to the waiting room, and the professor proceeds with the next. In one morning one may see six or more operations done, sometimes quite strenuous ones. Thus, on one occasion, I witnessed an excision of a goitre, a gastrostomy for inoperable cardiac end carcinoma (after an exploratory laparotomy), two amputations of the breast, and a Maydl's operation (total extirpation of the bladder with implantation of the ureters into the sigmoid flexure). The professor operates quickly, and very dexterously, but the suturing, closing, draining, etc., are done by the

assistants. When he is not operating he is washing his hands, and neither the ablutions nor the operation itself interferes with his speaking. It is an endless lecture, diversified with brief comments on cases, stray notes on diagnosis and treatment, and here and there an anatomical hint. On the whole, it is elementary; the senior student would not gain much, except by watching the technique of the operator. This is, in many points, interesting. Careful sterilisation of the hands is well attended to. When the professor has thoroughly washed them in soap and running sterilised water, he scrubs them, beyond the elbows, with absolute alcohol, and then dries them carefully on a sterilised towel. Sister comes round with the chiroseter spray,* and his hands are well sprayed. In septic cases, the spray is left off, the hands are dusted with sterilised boric powder, and dry gloves of thin rubber used. Local anæsthesia is very much used. The latest method is to inject the solution directly into a vessel, a bandage being applied above and below the site of anæsthesia. This method seems to be an admirable one in some cases. In a case of wiring of the olecranon a bandage was tied round the fore and upper arm, and the solution was injected directly into the veins. The anæsthesia was excellent, and the patient bore the operation without a twinge. In other cases, adrenalin is added, not so much to prevent hæmorrhage, but to "keep the anæsthetic as much as possible localised by constricting the vessels." In large operations, general anæsthesia (ether by the open method) is used, generally preceded by an injection of scopolamin-morphine. The Maydl's operation was done (within half an hour) under spinal anæsthesia, the patient receiving an injection of scopolamine-morphine an hour beforehand. This combination of lumbar with scopolamine-morphine appears to be really excellent, as it, to a large extent, makes the patient easy and comfortable, and, above all, seems to destroy the fear of operation in nervous patients. Hyoscine is not used and has never been tried. For local anæsthesia on mucous surfaces cocaine in one per cent. solution is used, novocaine being practically useless here —a point which is worth remembering in cystoscopy or laryngeal work where the relatively less toxic anæsthetic would naturally be preferred. The method of injecting the solution directly into the vein appears to be admirable in selected cases where it is possible to carry it out. I saw the Geheimrat operate on a ten year old boy anæsthetised in this manner, and the anæsthesia was exceptionally good, the patient even looking round to see what was being done, and calmly watching the work. The operation in this case was not a slight one—it was a case of extensive tendon transplanting in the forearm for inveterate post-hemiplegic choreic spasm that practically rendered the left hand useless; the moment the novococaine was injected the spasms ceased, and total anæsthesia, with loss of muscle sense, was present fifteen minutes afterwards, and retained during a long and difficult operation in which the interosseous membrane was perforated and large and deep incisions made on the flexor and extensor surfaces of the hand. The operation was successful in so far that the spasms have ceased, and the boy can use his left hand, but it is much too soon to judge of the "cure" that is claimed, and the foot, which is also affected, has still to be operated upon. In another case—a resection of an old tubercular knee ankylosed in a very bad position—the operation was indeed a revelation of the possibilities of local anæsthesia. The patient, a nervous fidgety man of 43, climbed up on the table, and the whole of his leg, from toes to inguinal region, was very carefully sterilised. Then the limb was emptied of blood by the Esmarch-Sylvestri method, and 100 cc. of a 2 per cent. novocaine solution injected directly into the internal saphenous vein, the incision for laying the vein free being made under an injection into the overlying tissues. Fifteen minutes later the operation was commenced, the patient bending his leg, and materially helping by such flexion the operator when the bone was sawn through. The sawn surfaces were approximated, and fixed by steel pins driven into the bone by means of a mallet; while this hammering process was going on the patient chatted quietly with the assistants. The operation itself was brilliantly done. The leg was immediately put up in plaster, the steel pins sticking out of the plaster casing, and the patient was put to bed, no cradle or special apparatus being used. Eight days later the pins were removed, and the leg appears to be firm; the patient has done excellently so far. This anæsthetic method is not perfect as yet, and it is only fair to say that I have seen failures. Bier insists on the necessity of completely emptying the vessels before the injection is made, and flushing out the unabsorbed cocaine solution afterwards with normal saline.

The best case of spinal (tropacocaine) anæsthesia I saw at this clinic was an operation for removal of periosteal sarcoma of the femur. The patient was thoroughly anæsthetic up to the region of the nipple, but was able to move his feet and lower limbs quite well, and he stood the severe operation—resection of half the pelvis, practically a "hind quarter amputation"—extraordinarily well. Whether the operation was justified is a point on which one need not express an opinion.

Another interesting operation was the Tagliacotian plastic operation for restoration of the nose in a patient who had extensive nasal destruction due to congenital syphilis. The operation was in four stages: (1) preliminary chondro-plasty (removal of part of the cartilage of a rib to form the new septum); (2) grafting this on to the upper arm and fashioning over the transplanted cartilage the flap of subcutaneous tissue and skin that goes to form the new nose; (3) freshening the nose so made and the site for it, and joining the arm to the forehead, and (4) dividing the flap finally and modelling the new nose if necessary. This method is said to give admirable results, but, as with other methods, one should be cautious in judging of its merits before seeing old cases, as the shrinkage must be considerable.

* Chiroseter is a patent compound, a mixture of wax in some volatile ether. It is sprayed on the hands, and said to be excellent, as it fills up the pores of the skin and prevents perspiration. Its use makes the hands very soft, and for plaster work it is admirable, as one need only rinse one's hands in warm water afterwards to get rid of the plaster, but for ordinary operative work it seems a most filthy prophylactic.

Attendance at operations is all very well, but teaches little except technique and a wrinkle here or there (such as immediate prothesis in a case of resection of the lower jaw, for example), nor is it fair, by watching operations, to criticise or compare the surgeon. None of the operations I have seen at Bier's clinic could be said to rival in excellence the surgery one sees in London, but that, after all, is individual opinion, which goes for little. Far more important is the practical teaching, and this is certainly, from a student's point of view, inferior to ours. Students' lectures are of three kinds, open clinical lectures by the Geheimrat in one of the wards, *privatim* lectures by one of the Privat Docent Professors, and *privatissime* or coaching classes, the best of which is the two-hourly class by Professor Klapp. These are all attended by students in what we would call their third year, and one misses the old practitioner

Whose hoar locks
Shine like the bubbling foam about a keel
When the prow sweeps into a midnight cove,

who attends operations in the morning, and follows the Geheimrat with rapt and awe-struck attention. At the *privatissime* of Prof. Klapp small operations are done, and the students are called down to assist, give the anæsthetic, or help in some other way. This course is thoroughly practical and interesting, much more so than the *privatim* or experimental surgery which Prof. Joseph gives twice a week. At this latter, vivisection experiments are regularly performed, though it is difficult to see what a student, who is supposed to know the elements of physiology, can gain from them. Thus, at the first lecture the professor dealt with blood coagulation, cut the carotid of a dog to show how it was tied, injected defibrinated pig's blood into a rabbit to prove that it could kill the animal, and then went on to explain how surgical operations could be performed on hæmophilics, after a preliminary injection of anti-diphtheritic serum—a theory which I supposed had been killed in its parturition. This course is really a mixture of pathology, elementary physiology, and morbid anatomy, and it is difficult to see what good purpose it serves. On the contrary, Professor Schmieden's course on practical surgery and instruments, bandaging, etc., is really excellent, while the operative courses are much better than ours, as they are taken by the head of the clinic, whose experience is of great value in assisting the men. A certain number of *privatissimi* lectures are given in anatomy, splanchnology, and osteology for the junior men, though not at this clinic. These are very good, the preparations being always demonstrated, and the lectures generally made interesting. The energetic student keeps very copious notes, and some of the note books I have seen are fearsome examples of misdirected energy, containing in a hundred closely-scribbled pages probably half-a-dozen gems. It is really a pleasure to wander from the Royal Clinic, with its interminable series of lectures, back to the Charité, and attend Geheimrat Bumm's admirable lectures. These start at twelve o'clock, and are the best clinicals I have yet attended here. For an hour the professor talks on a special lesion, half-a-dozen patients are shown, students being called down to examine them, and then several more are presented to show with what lesions a similar case might be confounded. Thus, at one lecture on syphilis, the first case was that of a woman who had been delivered of several stillborn syphilitic children. Forceps were put on, in front of the class, and a living child extracted, while the Geheimrat delivered an interesting lecture on syphilis in connection with pregnancy, displaying in it a very thorough acquaintance with French, English and American work. Then three cases of syphilitic lesions were shown, and these were followed by a series of lesions which might be mistaken for similar conditions, such as kraurosis, carcinoma, rodent ulcer, etc. After that, the operations are proceeded with.

The surgical student in Berlin has, on the whole, much less chance of doing practical work than in England, in strong contrast to the qualified student, who has much greater possibilities for ward work than with us. Up to the time the former takes his M.D. degree, he attends lectures, assists, in a perfunctory manner, at operations, and goes round, once or twice a week, with the professor. He does not write out reports, and the work he does is chiefly that of "assistant surgeon's dresser." That is to say, he attends out-patients, does minor dressings, and is shown how to examine cases. His M.D. degree is therefore a purely theoretical degree, and it does not confer the right to practise. That can only be obtained on passing the stiff and thoroughly practical "State Examination," a necessary preliminary to which is a year's ward practice. For that reason every graduated student tries to get an appointment as volunteer assistant at a recognised clinic, and as such he has good scope for practical work. The volunteer examines new patients, writes out their reports, does the clinical research work, performs dressings and minor operations, and acts generally as clinical assistant and full dresser rolled into one. There is no fixed term for this appointment; the volunteer may remain for years, or he may leave after a month if he does not like the clinic, and attach himself to another professor. If, however, he works well, he passes his State examination (how exacting and full this is may be seen from the excellent paper of Sir Felix Semon, published some time ago in the *Lancet*, in which an account of the author's own State examination is given), and may then be appointed a full assistant. The full assistant answers to our house-surgeon and assistant surgeon combined. He has charge of a ward—generally 20 to 30 beds, or in the large hospitals as many as 80—and is responsible only to his chief. He operates on emergency cases, does "secondary operations," and treats the patients, supervising the volunteer assistants, and dressing to his chief at the major operations. In some cases the full assistants are men of almost as great a reputation as their chiefs—professors of the University and specialists who have been in practice for fifteen or twenty years. In most cases there is a rule that the assistant in the wards should be unmarried; if he marries, he is transferred to the out-patient department.

He receives a salary and quarters; the volunteers only receive their lunch free, and have to board and lodge themselves, except in some cases, as at the city infirmaries. The result of this system is that the head of a clinic has a permanent firm, trained for his work, knowing his methods, and thoroughly capable of managing things in his absence. The solidarity of such firms, and the hero-worship or feeling of affection that bind them to their chief are, therefore, in many cases most striking. It is usually the case that when a full professor resigns his clinic to take up work at another University, his staff of assistants follow him in a body. Thus, most of Professor Bier's assistants, with Professors Schmieden and Klapp at their head, followed their chief from Bonn when he accepted the call to Berlin on the death of Excellency von Bergmann, and doubtless Professor Lange, if he decides to leave Munich and come to Berlin to occupy the chair of orthopædics vacant through Professor Hoffa's death, will bring his own firm with him. In their chiefs, the assistants, both volunteer and full, have a sturdy champion and a firm friend, whose support is often of the greatest value to them in obtaining teaching or other appointments. To become a volunteer assistant at a clinic, one applies to one of the full assistants in whose ward or department one wishes to serve. Hitherto such positions have not been difficult to obtain, but at the end of the present term the new regulations, prohibiting anyone who does not possess a German University degree from serving as a volunteer, except in very exceptional circumstances, will be enforced. Having received the assistant's sanction, the volunteer proceeds to the ward and is introduced by the assistant to one of his colleague volunteers. Further introductions he makes himself by walking up to any white-coated individual he sees, bowing and saying his name, "Jones," whereat the white-coated one returns the bow and says, "Smith," or whatever his name may be. Introductions satisfactorily over, the colleagues show the volunteer his beds, initiate him into his duties, warn him of any peculiarities which the assistant in charge of the ward may possess, and help him for the first day. After that he struggles along on his own hook. With the chief of the clinic, the Geheimrat, he has really little to do; he worships at a respectful distance, and shivers with delight when he is allowed to cut the ends of a ligature after the chief has tied the artery. With his own chief, the assistant, however, he has much to do, and usually the relations are very cordial, the assistant helping the volunteers, taking them to private operations, or assisting them in special research work. This last point is very much attended to, volunteers being encouraged to investigate special cases, which the assistant takes care are published or read. In this way the volunteer is enabled to make a reputation for himself, and so to attract the attention of the deities at the head. This is one of the most praiseworthy features of the volunteer system, and the chiefs often give away original ideas to their volunteers to be worked up. Thus the Sauerbruch cabinet was the outcome of a suggestion made by Mikulicz to one of his volunteers.

At the Royal Clinic the most interesting observations are to be made in the wards and out-patient rooms, in comparing methods of treatment. Necessarily, there is much which, to a Guy's man, would be heterodox; but there is equally much that seems worthy of following. The new way of putting up a fractured clavicle, for instance, in plaster, with the arm rotated outwards and the elbow bent at right angles, so that the poor patient has to go sideways through the doorway, is not one that commends itself to us, who obtain good results with our own methods. Equally little does the chiroseter spray appeal to one, or the aspiration of psoas and iliac abscesses through windows cut in a plaster splint, or, again, the tight bandaging, in an over-corrected position, of small babies with wry neck. One may find many other methods that are open to criticism, but, at the same time, there are others that impress one with their possibilities. One of these is the treatment of hyperæmia. Here, where Professor Bier himself is in charge, there is a special hyperæmia room, where out-patients are daily treated, both by the bandage and by the suction method, and the results are, on the whole, very good. I have specially noted cases of bad mammary abscess that have done wonderfully well under the suction treatment, combined with small incisions. How well the method answers in tubercular cases has already been stated, and certainly for knee and ankle cases it succeeds admirably. In acute cases, such as acute rheumatic arthritis, the bandage is put on for twenty-four hours: in chronic cases, for one hour. The hyperæmic treatment is by no means a panacea for all inflammatory evils, and it is insisted upon that it should be tried only in a systematic and regular manner, in accordance with definite rules. As used here, at this clinic, the results are most encouraging, and my two months' daily attendance in the hyperæmia room has made me a convert, though from what I had seen elsewhere of the application of the method I was by no means inclined to think highly of it. Perhaps the adjunct treatment which patients receive in the massage room—where the massage is carried out on certain well-defined "anatomico-physiological" principles, and not, as one so often sees it done, in a perfunctory manner, without reference to the lay of the deeper muscles or the lymphatics—is largely responsible for the excellent results.

I have dwelt so long on the Royal Surgical Clinic in the Ziegelstrasse that there is very little space left to deal with the other surgical clinics—not to mention the vast number of other interesting matters which appeal to the stranger. The difficulty of "getting at" medical novelties that have a bearing on surgical subjects has already been alluded to, and the three most interesting medical novelties really demand an extended description and consideration which cannot be given here. They are, of course, the Wassermann syphilitic reaction, the Sahli sphygmobolometer (which should prove of value in the investigation of surgical shock, collapse, etc.), and

electro-cardiography, which appears to be of assistance in diagnosing between purely nervous "hearts" and those in which a real muscle defect exists. Nor is it possible to do more than allude to the many "sights" that a medical student, interested in hygiene and social-economic questions, should not fail to inspect. First of these come the hospitals, with the Virchow at the head, and, next to it, the much more efficient, cheap, and thoroughly-equipped Moabite, followed by the Friedrich-shain, Urban and the private hospitals, such as the Hebrew, the Catholic, etc. Then there are the large "People's Baths" and "Public Gymnasia," which are really features of modern Berlin; the complete new sewage disposal works, as fine and as interesting as those at Sheffield; the abattoirs, or public slaughter-houses, where one can spend an instructive morning in inspecting the various arrangements to ensure a supply of sound meat for metropolitan consumption and the markets. The visitor should not fail, even if he cannot find time to see these, to run out to Charlottenburg, and inspect the Forest School for weak and delicate "school-board children"—one of the most sensible and most successful of such establishments I have yet seen. A visit to one of the large new barracks is also interesting, and can generally be managed, while here and there one lights upon another good thing. I had the pleasure of going over the new Nurses' Home, at the Moabite, with the Frau Oberin (matron), who was good enough to give me an account of the typical nurse's career, and to explain the rather complicated diet scales. The Home is thoroughly up to date, the bedrooms large, well lighted (generally overlooking the park and on the first floor), and very nicely furnished. Probationers have to pass a fairly stiff medical and general examination, but pay no fees, receiving, after three months' trial, pocket money, at the rate of ten shillings per month, and board and lodging, of course free. After eighteen months' probation, they become "sisters," that is to say, nurses; after three years, Ober Schwester, or head sister, which is really equivalent to our sister, although even then they are not in charge of a ward. Full ward sister comes later. The nurses in the Berlin hospitals are very good, and compare well with those in English hospitals. Many of them take a great interest in their work, and seem to specialise as well. The instrument sister is usually able to tell you all about the tools, as I found out, on more than one occasion, by asking for some particular instrument by its catalogue name, as Mathieu's tonsillotome, Mackenzie's ditto, Ferguson's forceps, etc. This is even better than with some of the Privat Docenters, who are apt to be somewhat rocky on foreign names. Thus, on one occasion, I heard the bone forceps, so pathetically associated with Ferguson's name, styled "Liston's forceps"—an unpardonable mistake for anyone who knows its history From their entry into the school the nurses are allowed "pension money," their board and lodging being reckoned as equal to £60 yearly for this purpose, and yearly they are allowed three to four weeks' leave of absence. Their hours of duty are almost identical with those at Guy's, except that there is no night sister, and the ward sisters have to remain half-an-hour longer on duty to report to the day sister. Many of the nurses speak some other language as well as German; I found two who spoke English.

The surgical student will probably find it worth his while to devote some part of his time to the Hebrew hospital to watch Dr. Israels, that brilliant but quiet surgeon with his patriarchal beard and his almost intuitive faculty for correct diagnosis. A more courteous and genial teacher it would be hard to find, and a list of the good things one notes down at his clinic would take up more space than the Editor could allow me. I will only mention one—a tubercular kidney case in which the kidney was extirpated at a very early stage, producing one of the prettiest specimens of commencing tubercular mischief—those tiny infiltrations at the tips of the pyramids, the pyramidal type which one reads of and so seldom sees. Whether extirpation was the right treatment I leave to others, who are not influenced by Mr. Godlee's views, to discuss. To me the interest lay in the fact that the condition had been rightly diagnosed at so early a stage, and on inquiry one found that the only symptom had been transient and slight hæmaturia. "I could feel both kidneys," said the operator, "and on cystoscopic examination the coloured solution flowed from the right ureter after fifteen minutes, while it didn't flow from the left at all." The methylene blue test is regarded as one of the best aids to diagnosis here; cryoscopy has been abandoned pretty generally, and its only strenuous defender (that is in its original form with a simultaneous determination of the blood-serum freezing point) is Oberarzt Kümmel, of Hamburg. Then, again, one should pilgrimage to the Kaiserin Friedrich's Hospital to see Dr. Gluck operate, although I have not been fortunate enough to see a total resection of the lower lobe of the lung—*the* Gluck's operation; and a visit to Professor Körte, who is a specialist on pancreatic lesions; to Dr. Krause, whose name is so well known in connection with the modified operation for resection of the Gasserian ganglion; to Professor Borchardt, who was Bergmann's first assistant at the Royal Clinic, and is now in charge of the surgical section at the Virchow; and to Professor Rotter, who is reputed one of the best abdominal surgeons in Berlin, is always worth while, though necessarily one may not strike an interesting operation on the particular day one happens to go to these various clinics. It is, however, impossible, at least for the student who wishes to do practical work while at Berlin, to find time to attend all clinics regularly, as in most cases the hours overlap, though with a well-arranged time-table it is surprising to find how much one can really see. Thus on a Monday one may attend Bier's operations from eight to eleven in the morning; then proceed to the Hebrew hospital and watch Israels till two o'clock, and put in an hour at Out-patients with Joachimsthal afterwards, ending the afternoon with a lecture at the Royal Clinic. Practical operative work on the cadaver one can do early in the morning; prac-

tical pathology early in the evening. On Tuesdays the programme is very similar, except that the midday visit is to Geheimrat Bumm's Clinic. On Saturdays, when there is usually little to be done at the Royal Clinic, one finds an hour or two to attend throat and ear outers at the Charité. A certain amount of energy and a good time-table are indispensable if the student wants to make the most of his visit, but the first is easily worked up and the second as easily arranged once the tram system has been mastered and the city map committed to memory.

Berlin, July, 1908. C. L. L.

Reviews.

The price of books submitted for review should in every case be stated.

Diseases of Women. By George Ernest Herman, M.B., F.R.C.P. Third Edition. (Cassell & Co.)

Several changes have been made in this well-known work which combine to bring it thoroughly up to date. The opening chapters, dealing with what the author terms "Minor Gynæcology," which is undoubtedly one of the finest pieces of modern scientific literature, have been improved by additional observations on the subject of hysteria.

The section on chorion-epithelioma has been completely rewritten, and is supplemented by three excellent micro-photographs; the latest work of Herbert Williamson and Atlee in connection with urethral caruncle, with their distinction between granulomata and new growths, is described.

The technique of gynæcological operations has been more carefully described, and brought into line with the latest improvements in method and after-treatment.

Both for examination purposes and for the use of practitioners, the book cannot fail to remain one of the best we have.

Cancer: Relief of pain and possible cure. By Skene Keith and G. E. Keith. (Messrs. A. & C. Black.) Price 2s. 6d. net.

This little book is a short account of the effect of repeated injections of a mixture of various substances into patients suffering from malignant disease. The authors herein publish the results of their treatment, taking each case separately.

Far too few cases have yet been treated to allow the authors to draw any conclusions, and they might well have waited until they have done more work on the subject before publishing what is, under the circumstances, a plain-stated, but nevertheless almost useless, production.

Special mention has been made of the devotedness to duty of Captain L. Humphry, R.A.M.C., during the recent outbreak of cholera amongst the British troops at Peshawar.—*The Lancet*, 25th July, 1908.

In Lighter Vein.

A Bacterial Ballad.

A song I would sing to the fame of a race
That is very well known to humanity,
By a knowledge of which one is able to trace
All diseases from boils to insanity.

Its members are many, and, though very small,
Are endowed with precocious agility;
They can wriggle and twist, and, rolled up like a ball,
Disappear with consummate ability.

Their number is legion, in fact, one might say,
They are well designated ubiquitous;
And I'm sure that you all will consider the way
They become propagated, iniquitous.

Just think, if you can, of the blood of a man,
In the grip of some germ microscopical,
The leucocytes fighting as hard as they can,
In a heat that is not far from tropical.

See shoulder to shoulder the oxyphils stand,
Some finely and some coarsely granular,
While lymphocytes small form a brave little band
(Their stained cytoplasm looks annular).

First a leucocyte scout, with an oxyphil shout,
Sends the news through the channels arterial,
That the phagocytes stout are in danger of rout,
At the seat of invasion bacterial.

Then arises from all a unanimous call
For a general leucocytosis,
And battalions are ready to fight and to fall,
And to conquer if Fate so disposes.

The invaders advance, and alas for the chance
Of the phagocytes being victorious,
One can see at a glance they will lead them a dance,
That their end can be nought but inglorious.

With a leap and a bound they spring over the ground,
Dealing death to all hostile corpuscles,
While lying around one sees mound upon mound
Of the dead, that will soon become pus cells.

But the end is soon near of this bloodthirsty war,
For the serum and cells leucocytic
Are piecemeal destroyed, but we'll see it is far
Otherwise with the germs parasitic.

For if cocci diminish in numbers, the rest
Reproduce them by binary fission,
And this terrible race, whom we all so detest,
Thus produce a toxæmic condition.

And now all is over, the battle is won,
And howe'er each may like "suam sortem,"
Cocci and corpuscles, when all's said and done,
Make a fine demonstration post-mortem.

"MERCURY."

Sport.

Swimming Club.

Final of Water Polo Cup.

GUY'S (Holders) v. LONDON.

This match was played on July 24th, at Aldgate Baths. Guy's lost the toss and had to defend the shallow end. From the start they showed their superiority. Glover reached the ball first, and, after a round of passing, secured the first goal. From a free throw Pritchard quickly put us 2 goals up. Goals now came freely from Moberley, Pritchard, Glover and all, and half-time came with Guy's leading by 7 goals to nil.

On the re-start we were again "all over" our opponents, who were obviously out of condition and not playing well together. But our shooting was very wild indeed, and the London goal-keeper defended excellently. Eventually time was called with our score still 7 goals to nil.

REMARKS.—The game was fought out keenly. Individually, Pritchard and Glover played on the top of their form. Our goal-keeper, Eccles, only had to touch the ball twice. The goals were scored by Glover (3), Moberley (2), Ball and Pritchard (1 each).

We now hold both the Swimming and Water Polo Cups for the first time. This success is due to the great keenness shown by all the men in both teams.

Our Swimming Team consisted of:—H. Glover, C. D. Roberts, G. B. Pritchard, A. Moberley.

The Polo Team:—H. N. Eccles (goal); G. B. Pritchard and H. Rice (backs); W. T. Clarke (captain) (half-back); M. E. Ball, H. Glover and A. Moberley (forwards).

Change of Address.

Dr. H. M. Clarke, from 160, Friar Street, Reading, to 58, London Street, Reading.

Dr. R. Denman, from Port Victoria, Mahé, Seychelles, to Ipoh, Perak, Federated Malay States.

Mr. W. S. Handley, M.S., F.R.C.S., from 77, Wimpole Street, W., to 12, New Cavendish Street, W.

Dr. E. L. Norton, from St. John's Hospital, Lewisham, to "Hill House," Rickinghall, Diss, Norfolk.

Mr. R. P. Rowlands, M.S. Lond., F.R.C.S. Eng., from 6, St. Thomas's Street, S.E., to 12, Queen Anne Street, Cavendish Square, W. Telephone No. 1017 Paddington.

Mr. C. Doswell Wallis, L.D.S., R.C.S. Eng., from 47, Chapel Road, Worthing, to 27, South Street, Worthing.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Births.

BATES.—On July 28th, at Beulah Hill, S.E., the wife of Joab Edward Lionel Bates, M.R.C.S., L.R.C.P. Lond., of a son.

HAYES PALMER.—On July 29th, the wife of P. H. Hayes Palmer, L.D.S., R.C.S. Eng., of 70, Crediton Road, Hampstead, N.W., and 112, Harley Street, W., of a son.

LUMLEY.—On June 2nd, at the Royal Naval Sick Quarters, Wei-Hai-Wei, North China, the wife of Staff Surgeon F. Davidson Lumley, R.N., of a daughter.

ROWELL.—On July 31st, at 6, Cavendish Place, W., the wife of George Rowell, of a son.

Marriage.

CLARKE—CROCKER.—On July 30th, at St. Margaret's, Upper Norwood, by the Rev. W. B. Taylor, M.A., Henry Milford Clarke, B.A., M.B., B.C. Cantab., of 58, London Street, Reading, to Marie Antoinette, eldest daughter of Capt. C. W. Crocker, of Ainsdale, Southport.

Death.

STEVENSON.—On July 27th, at Sandhurst Lodge, Streatham, Sir Thomas Stevenson, M.D., F.R.C.P., aged 70.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE education of the medical student is, at the present time, attracting much attention, so that the discussion at the recent meeting of the British Medical Association, held at Sheffield, was followed with much interest. The discussion took the form of two debates, one under the auspices of the Anatomy Section, and the other under those of the Physiology Section. Dr. Christopher Addison opened the former. He emphasised the fact that the present-day teaching of anatomy has evolved a system by which students are made to rely more on their memories than on their faculty for observation; that magnificent text-books have, in a measure, done away with the all-important necessity of personal dissection, and have made the task of learning anatomy merely a feat of memory. He thinks that the increased attention devoted to detail is a harmful procedure, in that it has resulted in students regarding the structures they have seen not so much in the light of what rôle they play in the body, as a list of subjects which have to be known if one wishes to be "signed up;" and, again, the system is apt to make men store in separate compartments of their minds structures which should always be thought of together; for example, the grasp of the hand is little understood if the student has the flexors stored in one compartment of his mind and the extensors in another.

THEN followed many speakers, and the note which predominated throughout was one which we think is the root of the evil—the fact that examiners are prone to exact from students these feats of memory rather than the results of personal observation and intelligent application in the dissecting room. The examiners in Anatomy are drawn from the teachers, and it is for them to institute the reforms.

PROFESSOR STARLING opened the debate, "The Preliminary Scientific Education of the Medical Student," in the Physiology section. His outspoken opinion must carry great weight, for his experience in teaching physiology, and of examinees, is greater, maybe, than that of any of his contemporaries. He regrets that the mind of a youth embarking on a medical career should be lumbered with so much scientific

detail which is insufficiently correlated to his future work. He holds that the mentality of an "average" student—who, says Professor Starling, is not by nature a scientist—is overburdened at the onset, and that the huge compendium of facts, with which he is stuffed in his first year, must either hinder him, if they are to be remembered, when he commences his study of anatomy and physiology, or else must be forgotten altogether, for even the best of sponges cannot absorb an unlimited amount of fluid.

REMEDIES were discussed. Professor Armstrong was in favour of radical changes in our educational system as a whole. Dr. Buist thought that elementary chemistry, physics and biology should be school subjects. Professor Sherrington also considered them school subjects, and thought that biology ought to be taught more from a functional than a structural point of view. The remedy which Professor Starling himself suggested was, that for the most part, these early subjects should be dropped, merely those parts which bear a direct relationship to the body in health and disease being retained.

So we see that the dissatisfaction which men so often express at the time wasted in acquiring their "early" subjects is shared by their teachers. One and all of the distinguished members present at the meetings of both these sections recognised the necessity of reform. Let us try and review what has led up to this state of affairs. In every branch of medical science great progress has been made; take, for example, anatomy, a subject which one would imagine was not capable of extreme advances; see the progress which embryology, neurology and the anatomy of the alimentary system have made. Physiology every day becomes a science of more alarming dimensions; whilst pharmacology is a great subject in itself; of pathology and bacteriology we need not speak. If, then, the present form of education is to be insisted on, the curriculum in a short time will be ten years. As Professor Starling aptly asked, "How many of the members present remember the skull of the dog-fish, or can point to any useful medical knowledge that has been derived from its study?" That is the whole crux of the matter. The early years are encumbered with the accruing of knowledge which is utterly useless in later days. Of course, the "scientific" education is necessary, but let it be of such a nature as to be correlated to latter-day requirements.

ANATOMY and physiology are great essentials. Cannot the knowledge of the "first year" be made to assist these more? And as regards their teaching, we have no doubt if the compulsory attendance at lectures be done away with, and more time devoted to better classified laboratory work, a better result would be attained. The London University has made one step in the direction of reform, a recognition that, as things stand at present, the time given for the curriculum is insufficient; they have lengthened this time by six months. May other reforms follow; but let them take the course of erasing the unnecessary, not adding to a period which is, at present, a considerable span of useful years.

MR. STEPHEN PAGET, in an address before the Abernethian Society, at Bart.'s, some short time ago, had some trenchant things to say of what he termed the opponents of our profession. In this category he included anti-vaccinationists, anti-vivisectionists, and Christian scientists; of quacks he said little, as time was pressing. The address is characterised by a logical candidness which does the heart good to read; for the profession is far too long-suffering in its acceptance of all the many opprobrious things that are

written and said of it. It might be worthy to retire behind a mantle of professional dignity, but the world moves apace now, and it's a poor chance a man has who does not speak for himself. Those members of the community who are ever ready to attack a weak spot in the armour of the medico are indeed numerous. They are, for the most part, illogical discontents, who echo the prevailing cry against authority; they show merely a phase of what seems a world-wide semi-anarchichal wave. No, it is not, individually, each one that matters; but it is the dissemination of their various ill-founded beliefs, by pamphlets and from platform, which does the mischief. Therefore, men about to embark on the troubled waters of general practice should be armed to meet these attacks, and break down, if possible, argument by argument, the illogical statements brought forward.

For the anti-vaccinationist—and, of all beings, he seems the most obdurate—there is the Jenner Society, which publishes pamphlets of such a convincing nature that even a mule-like "conscientious objector" may be persuaded to view things from a different aspect.

As regards the anti-vivisectionist, the Research Defence Society is daily gaining more power in its fight against the malevolent faddists whose forte is the misinterpretation of salient features plus the misrepresentation of the same to a section of a public, neurotic and gullible. The Society was long in appearing—too long—but now that it has arrived it should have the support of all lovers of Truth.

Christian science is yet another phase of the present-day rebellion against the old order of things. Just as the Romans tired of their gods, and sought those of Egypt, so do these followers of Mrs. Eddy turn and welcome a code which in its conception is as impure a caricature of sane thought as was the Egyptian deities of the gods of Rome. It was the upper classes then, and it is the upper classes now. An early sign of degeneracy this. Merely an excuse to relieve the ennui of a life overcrowded with pleasures. What of its message to the poor? To the rich it gives a salve; they need not worry much over their sins, and above all its air of pseudo-intellectuality is pleasing to the vanity of the disciple.

One might ask why all this pother over a "harmless eccentricity"? Well, in most cases it may be harmless, but it is as well, when men go out into the world, to be prepared to meet it, and, if possible, overcome it. They should be prepared to show that the non-cessation of Plague in India is not due to Haffkine's treatment, that diphtheria anti-toxin, though it be but an "animal filth," is a necessary and somewhat potent remedy, for many such wonderful statements will they hear. And it does get on one's nerves so!

The improvements in the Operative Surgery department are progressing apace. During the excavations necessary for strengthening the foundations, the workmen discovered an old bricked-in culvert. This was probably an open sewer which in ancient days led into Maze Pond. Nothing of interest except some much-battered pewter was found therein. The underground geography of the Hospital abounds in wonderful things. To an ardent tourist who finds it at present difficult to get away to the catacombs of Paris or mysteries of Pompeii, we recommend it as a substitute.

The march of the woman proceeds! At the last meeting of the Royal College of Surgeons of England, Mr. C. T. Dent gave notice of moving at the next meeting:—

> "(1) That steps be forthwith taken to admit women to the examinations of the Conjoint Examining Board of England and to the examination for the Diploma in Public Health. (2) That women be admitted to the examinations for the Fellowship of the College and to the examinations for the Licence in Dental Surgery."

It was pleasing to see that at the British Medical Association's Meeting, much honour was done to Professor Neisser. This distinguished member of our profession, a man of means, has devoted many valuable years of his

life in the East, working on the cause and cure of syphilis. It is interesting to note that he now advocates a free incision and removal of the primary sore. In apes, Professor Neisser has found the effects of this line of action desirable; it remains to be seen what the early removal of the local nidus will do in the human being.

An excellent obituary notice of the late Sir Thomas Stevenson, from the pen of that talented and versatile writer, Mr. T. P. O'Connor, appears in the number of *M.A.P.* of August 8th. T. P. seems to have been much struck with what most of us had always noticed. When the great medico-jurist was described as the man who had hung more wrong-doers than any man alive, one unconsciously conjured up more or less a grim picture, a stern set face with unsympathetic eyes and a brusque address; instead of that, one met a kindly face with eyes soft and full of sympathy—but none the less shrewd—surrounded by "wrinkles of laughter," and a voice which was soft, intonating, and kindly. If ever a mien denied the characteristics which might have been, from the grimness of its owner's work, attributed to it, that of our much-beloved lecturer in Forensic Medicine did.

T. P. tells of the Maybrick case, with its exciting trial, in which partisanship was so marked. He tells how, when burning doubt was in every mind, and excitement at fever pitch, "a quiet, soft-spoken, reticent man with a kindly face" entered the witness box, and, in a soft voice, told of his analysis, concluding with the words, "I can have no doubt that the cause of death was irritant poisoning, and I have found that poison." Doubt vanished then, and a conviction was obtained.

Sir Thomas did not escape scot-free from the partisanship, as a letter to the *Lancet* from Dr. Lowndes shows, for on returning to his hotel after the trial he had to carry his own luggage to the cab, the servants refusing. Perhaps the greatest achievement of the great expert was the detection of aconite in the Lamson case. In our last issue, our correspondent, R. B., told of it.

As T. P. remarks, the contrast between Sir Thomas's sordid surroundings when engaged in sending some wretch to his well-deserved fate, and the quiet and peace of his Streatham home with its garden, was marked. A great man has passed, and the world loses much.

The Annual Dinner and first meeting of the Physical Society will be held on October 8th. The meeting will be preceded by the Dinner, which, as usual, will be served in the College; Mr. Cosmo Bonsor will occupy the chair. At the meeting Sir R. Douglas Powell, Bart., K.C.V.O., has very kindly consented to deliver an address entitled the "Just Procedure of Medicine," whilst Dr. Goodhart has promised to officiate as chairman. Tickets for the dinner (3s. 6d. each) may be obtained from the Secretaries, from any of the Presidents, or from the Caterer.

The Library will re-open on September 1st. Men may obtain the Gazette from the Treasurer's office.

Reviews.

The price of books submitted for review should in every case be stated.

A Manual of Medical Jurisprudence, Toxicology, and Public Health. By W. G. Atkinson Robertson, M.D., D.Sc., F.R.C.P. Eng., F.R.S. (Simpkin, Marshall & Co.) 8s. net.

This is indeed an excellent manual. It presents the subjects in a most readable form, and in such a manner that from the point of view of the student it constitutes easy reading. The section on Medical Jurisprudence contains concise chapters on criminal procedure, medical evidence, examination of the dead, modes of death, etc. interspersed with useful illustrations of cases, many of them most recent in occurrence. The Public Health is dealt with in a concise, explicit manner, which is quite comprehensive enough for the purpose of most final examinations, though maybe it need be supplemented by reading from larger books for some of the Finals in which greater stress is laid on this department.

The Toxicology is in a form which will be appreciated by those whose time is limited. Bearing in mind the size of the manual it is excellent value, and will be found especially so by those men who are taking the Conjoint diploma.

Life in the I.M.S.

By Captain Watts.

A Night in a Tree.

It is the middle of June, and I have visited the last of the villages in my district, plague-infected during the preceding cold weather, so, as I am on the outskirts where the low hills come down to meet the plain, I determined to have a day or two's rest before returning to headquarters and the monotony of station life. The bungalow in which I am stopping is situated on a low spur running out into the bed of the Jumna, turbid from the melting snows, and gets the benefit of every breath of air that moves, be it ever so light. Thick thorn-tangled jungle comes up so close that jungle fowl and partridges may occasionally be seen feeding on the grassless lawn, and panther tracks within a few yards of the back door.

Half-past six sees me moving off with the local Shikari, who has shot everything from a tiger to a snipe, all with the same old worn and battered twelve-bore. His usual white pugaree and voluminous garments are now replaced by a little skull cap, which looks rather ridiculous perched above his bushy black beard, and a suit, whose only recommendation is its entire lack of anything approaching distinctness of colour or pattern. A strong wind is blowing from the north-west, heated by its journey across many, many miles of dry parched plain—so hot and parching that after a tramp of some miles along close stony jungle tracks, one's thirst is intense, though one has hardly sweated a drop. However I have no intention of suffering from thirst, as I have stipulated that a "ghunah," or earthern jar, holding several quarts of Jumna water is to accompany me—water that, though when first drawn is thick and turbid, soon clears to quite a tolerable condition, and is refreshingly cold.

A tramp along the more or less grassy sides of a sluggish stream brings us to its source, a spring fouled and betrampled in the day by cattle, and at night by every animal that haunts the thick dense jungles close at hand. By the time I am seated cross-legged on a native string bed, cunningly and securely fastened in a convenient tree with a screen of bushes all round, the sun is fast sinking towards the low hills in front, a sardonic grin on his broad red face, promising a short absence with only an all too brief respite from his fiery rays. Only with the sunset has work for man and beast ceased; now, no longer can be heard the ploughmen encouraging their oxen with weird noises as they plough the hard dry ground, nor the cattle-bells tinkling as the clumsy lumbering buffaloes slowly wend their way homewards from their feeding grounds on the edge of the jungle to the group of straw-thatched huts, where their evening meal of chopped straw is waiting, an insignificant boy usually bestriding the ugliest, oldest, and heaviest, which he thumps and abuses.

Now only are to be heard the occasional cry of a child and the barking of village pariah dogs. Darkness has fallen, but with it comes the night's own sounds. The dry cracked earth opens its parched throat and seems to cry aloud for rain, while all around slight trivial sounds break the silence as the jungle folk bestir themselves to seek their nightly food. Above all is heard the monotonous metallic note of the nightjars, Tonk! tonk! tonk! Suddenly the whistle-like call of a cheetal (spotted deer) is heard not far away; his calling, before daylight has hardly gone, means something has alarmed him—probably a panther, as the haunts of the tiger we got news of are some miles away. With a hurried scurry, a snort and a grunt, a dark form dashes under our tree, and is soon wallowing in the muddy water. We do not require our eyes to tell us that a pig has been the first to come. We are by now interested, and strain our eyes to pierce the darkness, when up with a bound springs a glorious full moon above the hills behind us, which floods the scene with light, rendering the dark shadows under the trees blacker and more mysterious than ever.

We can now see pig moving in all directions, singly and in groups, rooting and squealing in the fields and undergrowth, but we want something better than them to-night. At last our shikari, whose bronze skin glistens in the moonlight, nudges us and whispers, "Jhonk" (spotted deer), and sure enough, after straining our eyes, a line of dim distant forms is seen gradually approaching. Though their bodies stand out black in the brilliant moonlight, their limbs cannot be seen to move, so that they seem to drift towards us rather than to walk; they file past within a few yards, but all are either hinds or small stags, so we let them go, much to the disgust of our villager, whose sporting instincts are, like all his kind, ruled by the natural desires of his stomach, and not by any vain wishes for trophies. Several more herds pass in like fashion before, at last, a solitary stag approaches, whose horns are good, so my shikari asserts. The stag seems suspicious, however, and thirty yards away turns and crosses the stream above us. A short pause, however, on the further bank gives the fatal opportunity; bang! goes my old Greener, and he is lying kicking in a cloud of dust, for a spherical bullet out of an ordinary twelve-bore will stop most things.

We have hardly got down, dragged him to the foot of our tree, and settled ourselves again, before more herds are passing, but now we are hard to please, and do not fire except at an old boar, whose big black form makes a mark hard to miss at a few yards distance. Hard hit though he is, he dashes noisily off into the jungle. A wait, and then a rustling below, makes me look down to find a porcupine approaching the dead deer lying at the foot of the tree. I twist myself round and try to cover him, but he hears the noise and retreats unharmed, though my clavicle is nearly broken by the kick of a loosely-held gun.

So the night passes, and, as we sit with the breezes, now pleasantly cool, fanning us, we can tell that the

jungle creatures are thoroughly awake, moving from their lairs n the dense forest, above whose dark jagged crest the stars are twinkling brightly. The harsh cry of jungle fowl, the gruff bark of the kaker (barking deer), the whistling call of the cheetal, and the bell-like note of the sambhur all help to keep us awake and interested. My shikari, who has been peering into a dense thicket, uneasily, for some little time, now swears he can see a sambhur, with splendid horns, but, though I strain my eyes until I can almost see fortification figures, ne'er a glimpse of anything four-legged can I descry, until I see two forms move out into the moonlight, two hundred yards away. It is an impossible shot; but my blood has been fired by the shikari's exclamations, and, as now the night is nearly done, I catch up my rifle and loose off at the first one. As might be expected, nothing happens, except that they move off at a gallop. However, there is still another cartridge, and, as they are now nearer, about one hundred yards away, I again let fly, and see, as I think, the front one stumble, but only to get up and dash off into the jungle. Almost immediately there is a clatter of stones, as though something has fallen, so we hastily descend the tree—so hastily that I leave bits of my skin and flannel shorts behind as mementoes—and dash off to the outskirts of the jungle, where, after a brief search, we find a sambhur lying dead, shot through the neck—as big a fluke as one could meet with, considering the light, distance, and pace they were moving at. We also find the corpse of my pig—a huge, hideous, bristling boar, on whose tusks the moonlight gleams.

It is now nearly four o'clock, and we are stiff and tired, so we pack up our belongings and move off to see what our friend has done, as we have heard several shots from his direction. We find him seated on a low bough, over the water, opposite a small clearing in the jungle on the opposite bank. Except for pig, he has not seen much, but he has killed a panther and fired at a sambhur, which got away owing to a bad cartridge. He makes the necessary arrangements for having the game carried to the bungalow, and we trudge the four miles home in the early dawn, I shooting a jungle cat on the way, and arrive back in time for an egg flip with a dash of brandy, a cold bath, and a sleep, all very welcome, after a long, tiring, but interesting night.

Change of Address.

Dr. H. S. Brown, M.B., from "Leyland," Wallingford Road, Goring-on-Thames, to 7, The Steyne, Worthing, Sussex.

Mr. C. H. Golding-Bird, from 12, Queen Anne Street, London, W., to Pitfield Cottage, Meopham, Kent. Telephone, 4 P. O. Meopham.

Mr. E. R. Tebbitt, from 42, High Street, Tunbridge Wells, to 4, Frant Road, Tunbridge Wells.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Pass List.

UNIVERSITY OF LONDON, July, 1908.—Preliminary Scientific Examination. Part II., Organic Chemistry: F. D. Annesley, V. Atienza, T. P. Cole, D. A. Davies, A. S. Erulkar, G. E. Genge-Andrews, W. S. George, J. F. Mackenzie, A. G. H. Moore, R. D. Passey, L. B. Stringer, S. Wilson, W. A. Young. Part I., Inorganic Chemistry, Experimental Physics and Biology: G. S. Miller, C. E. Petley, C. S. L. Roberts, H. C. Rook, C. Sherris, W. L. Webb, O. R. L. Wilson; Inorganic Chemistry and Experimental Physics: G. D. Eccles; Inorganic Chemistry and Biology: A. C. Hancock, J. A. Ryle; Inorganic Chemistry only: W. L. Gwyn-Davies, F. H. Dodd, W. L. E. Reynolds, L. Muir Smith; Biology only: W. Robinson, A. L. Shearwood, A. J. E. Smith.

ROYAL ARMY MEDICAL CORPS.—S. M. Saunders, D. E. G. Pottinger.

INDIAN MEDICAL SERVICE.—A. S. Khan, H. Stott.

LONDON SCHOOL OF TROPICAL MEDICINE.—C. A. L. Mayer.

Appointments.

Civil.

CARR, T. E. A., M.B., B.S. Lond., M.R.C.S., L.R.C.P., has been appointed Senior House-Surgeon at the Birmingham and Midland Eye Hospital.

FORTESCUE-BRICKDALE, JOHN M., M.D., B.Ch. Oxon., has been appointed Honorary Assistant Physician to the Bristol Royal Infirmary.

RATTRAY, M. J., M.R.C.S., L.R.C.P. Lond., has been appointed Resident Medical Officer at the St. Pancras and Northern Dispensary, Euston Road.

Naval and Military.

Surgeon R. W. BASIL HALL, R.N., is promoted to be Staff Surgeon in his Majesty's Fleet.

Staff Surgeon J. C. G. REED, R.N., is appointed to the *President*, additional, for a three months' course at West London Hospital, and Surgeon HARRY M. LANGDALE, R.N., is appointed to the *Cadmus*.

Captain H. HEWETSON, R.A.M.C., is promoted to be Major.

Major BAMAN DAS BASU, I.M.S., is permitted to retire from the Service.

From the Gazette's Special Pathologist.

E. M. H., HUDDERSFIELD.—This is a malignant growth of an unusual type. Much of it has the honeycombed structure of an angioma, and some of the spaces are filled with fibrin, others with granular deposit suggesting lymphatic channels. The stroma and surrounding parts are composed of small spindle-celled sarcomatous tissue. The growth probably belongs to the class of endotheliomata, but may have taken origin in a persisting capillary angioma, or lymphangioma.

G. M. J., ALTON.—This film contains many pus cells, but no Gonococci are found.

E. H. G., AMERSHAM.—Two of the hairs in the mounted preparation show a very slight infection with the Ringworm fungus. The parasite is most probably the Ecto-endothrix variety. PATHOLOGIST.

A Case of Inoperable Malignant Disease treated with X-rays.

CLINICAL LECTURE BY Dr. IREDELL.

Gentlemen,—I propose to discuss, to-day, the influence X-rays have in retarding the course of malignant disease of the breast. The case I have chosen, as an example, is that of a woman, aged 54, who came up to the Light Department for X-ray treatment in March, 1907. In March, 1901, her breast had been removed for growth, and she had remained perfectly well until October, 1906, when she noticed a pricking pain, and shortly after a small swelling in her sternum. This pain became worse and the swelling larger, and twice she went about it to Mr. Dunn, who on the second occasion advised her to have X-ray treatment. On examination there was an irregularly circular tumour of the sternum, two and a quarter inches in diameter, involving the second and third right costal cartilages (Fig. 1). It was slightly tender on pressure,

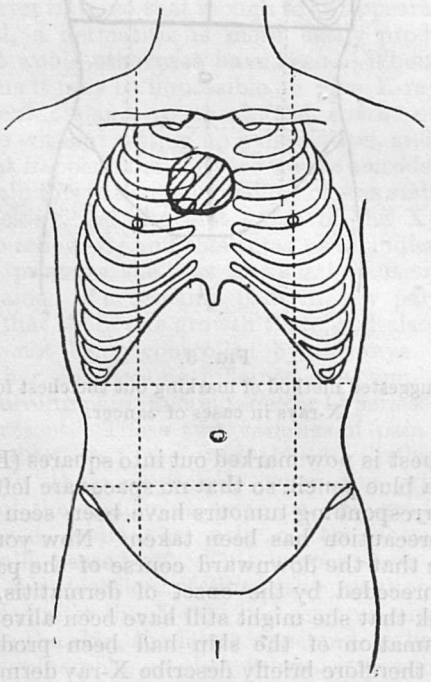

Fig. 1.

and the skin covering it was normal. The right breast had been removed, and the scar was healthy. No enlarged glands could be felt about either clavicle or in the axillæ. She complained of a "pricking, stabbing" pain which was constantly present, with paroxysmal exacerbations which were very severe, and frequently prevented sleep at night. Her appetite was bad, and she had a distaste for food. The tumour was treated with X-rays for fifteen minutes three times a week, with 2/10 milliampère running through the X-ray tube. In the following month the pain was better, and the paroxysms had stopped. She was able to sleep at night, and the tumour, which had lost its tenderness, was smaller. She complained of a fresh pain in her neck and down the left arm, and of attacks of difficulty in breathing, like asthma. Enlarged glands were felt in the left supra-clavicular region. This was X-rayed, and the pain soon passed off, and later on the attacks of difficulty in breathing stopped. The tumour of the sternum gradually became smaller, until in September it had disappeared, and the patient became free from pain and was well. There was a small swelling on the lower part of the sternum about as big as half a pea, and enlarged glands could be felt above both clavicles, those above the right being felt for the first time. On several occasions X-rays had been omitted so as to avoid setting up a dermatitis.

She continued well until October, when treatment had to be omitted because of a tingling pain in the neck and chest. In December, 1907, the glands above the clavicles were not palpable, but she developed a cough and was never really well again. The X-rays were continued, but had to be omitted frequently on account of her increasing liability to X-ray dermatitis. The pricking pain of the growth was present in the neck on several occasions.

When she came for the last time at the end of February there were small swellings at the inner end of the left clavicle and at the lower part of the sternum. The glands above the clavicles were just palpable, and there were enlarged glands in the right and left axillæ (Fig. 2). There were no signs of infection of the liver, brain or spine. She seemed very ill, and complained of bad attacks of asthma, but not of any severe pain. There was no sign of the original tumour, and those tumours which were present were small and comparatively insignificant. She died shortly after, seemingly from mediastinal growth.

In a few words, the course her disease took was this: She improved in her general condition for five months, at the end of which

time she felt perfectly well. The original tumour had cleared up, while others had appeared. She remained well until a dermatitis had been set up, and two months later she began to go down hill.

If we consider the spread of the disease we see that the distant parts of the body were not affected, but only those which were near the original tumour; so that if we suppose that the outlying parts of the disease had not been treated we can see how enlarged glands in the neck and axillæ occurred. It is well known that a surgeon, when he operates on a malignant tumour, removes a wide area of apparently

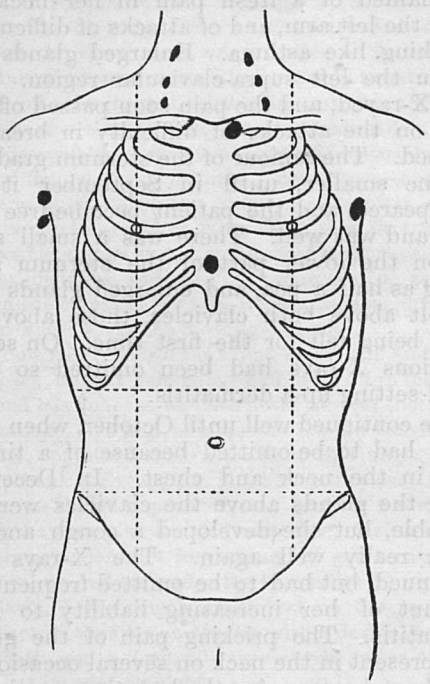

Fig. 2.

healthy tissue, and that it not infrequently happens that he finds that the disease has spread far more widely than he had at first thought. I think that neglect to treat widely round the tumour in this case was probably the cause of the appearance of fresh growths. At the present time in the Light Department each patient with cancer of the breast has the whole of the front of the neck and chest X-rayed regularly. The explanation of the occurrence of tumours on the inner end of the clavicle and on the lower end of the sternum is not so simple, for these appeared while the whole of the chest was being treated. You will notice that the chest was divided into four-inch squares, and that these two tumours were on the edges of them. Two explanations, I think, are possible; one is that the rays at the edge of a four-inch square are less intense than they are in the middle, and therefore an amount of X-rays that would prevent the occurrence of growth in the centre of a square did not prevent it at the sides; the second is that in treating the patient a space may unintentionally have been left between two adjacent squares, and this space therefore was treated insufficiently. To prevent this happening,

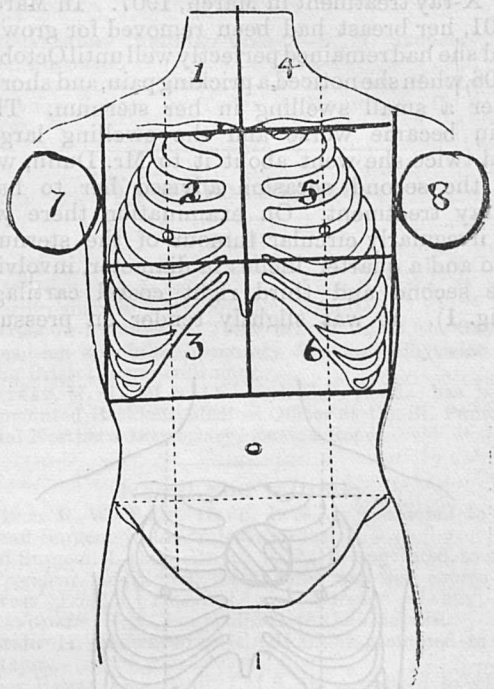

FIG. 3.

Suggested method of marking out the chest for X-rays in cases of cancer.

the chest is now marked out into squares (Fig. 3) with a blue pencil, so that no spaces are left, and no corresponding tumours have been seen since this precaution has been taken. Now you will notice that the downward course of the patient was preceded by the onset of dermatitis, and I think that she might still have been alive if no inflammation of the skin had been produced. I will therefore briefly describe X-ray dermatitis and the means that can be adopted to prevent it. In the first place, I wish to point out that although an X-ray dermatitis may have such terrible results as to necessitate amputation of

the hands, it is quite possible to have an inflammation of the skin due to X-rays which may be so slight that it is not noticed by the patient. Secondly, before the necessity of protecting X-ray tubes was understood, the two hospital electricians worked in one case for five and in the other for three years in the X-ray Departments without any signs of dermatitis, though they were taking no precautions, so that it is possible to be under the influence of X-rays daily for some years without being burnt. When small doses are given the different stages of inflammation follow one another fairly regularly, so that by watching for the early signs it is possible to prevent any harm being done. The first sign of reaction of the skin is bronzing, and I should like to point out that the statement sometimes made that bronzing of the skin shows that dermatitis will not occur is incorrect, Next, a red flush appears over the skin; this is followed by the onset of pain, and lastly there is vesication and ulceration. An interval of a week or more elapses between each stage, so that leaving off treatment at the beginning of one stage is sufficient to prevent the next being reached. When pain and vesication have been produced, the skin becomes altered for a longer or shorter time, so that though to all appearances normal, a dermatitis is more easily produced than it would otherwise have been. When this happens it may be impossible to give X-rays in sufficient amount to check the course of the disease without setting up a dermatitis, and this is what happened in the case we are considering. The pain this patient complained of was stabbing or pricking, and the first effect of the X-rays was to relieve it; and this acted as an indication of the progress she was making, because if she complained of a pricking pain in any part we knew that there was growth there, and also that it was not being controlled by the rays. But when her skin became inflamed she complained of a burning pain, and cutaneous hyperæsthesia was present. These two varieties of pain were so distinct that she was able to distinguish between them, especially when the pricking pain of the malignant came on and gradually increased, while the pain of the dermatitis gradually passed off. This happened on more than one occasion. When the reaction had subsided after the X-rays had set up a smarting pain in the skin, the latter appeared to become more vulnerable, so that it was impossible to give sufficient X-rays to the growth to prevent its spread without producing a dermatitis. Now this irritable condition of the skin does not occur as a rule without a preceding dermatitis, so that the importance of not producing any inflammation of the skin on account of the after-effects becomes obvious.

When treatment was first started, this patient was having almost five times the dose of X-rays that is found sufficient now. I say almost, because less current was run through the X-ray tube, and therefore fewer X-rays were given off. It was hoped by leaving off treatment occasionally that the production of a dermatitis would be avoided. But in this case, as in others, it was found that a dermatitis could not be avoided indefinitely, and experience at Guy's seems to show that small doses frequently repeated without omitting treatment give the best results. Reducing the amount of the dose and giving it more frequently diminishes the risk of producing any inflammation. Thus, if it is desired to treat with X-rays for nine minutes once a week, in about two months there will be the early signs of dermatitis. But if three minutes' treatment is given three times a week, uninterrupted treatment will be possible for much longer. The action of the rays on the growth will be almost the same in the two cases, whilst in the second the risk of dermatitis is much diminished. In some of the published cases of X-ray dermatitis a note has been made of the fact that the inflammation has been sharply marked off by the edge of the clothes, and I think that linen and similar material have a greater effect in stopping at all events the rays that damage the skin than one would be disposed to think, if one considers how little difference a surgical dressing and bandage make on the X-ray screen if the limb is being examined. On this hypothesis two thicknesses of lint are sometimes put over the patient's skin where it is being treated, and I think that this diminishes the risk of a dermatitis while the effect on the growth is unaltered. The tubes used in this case were those whose equivalent spark gap was three inches, but the rays from higher tubes than this are more penetrating and less likely to produce a dermatitis, and so with these more satisfactory results may be obtained.

A microscopical examination of one of the glands which was removed from the neck of this patient showed the growth to be a spindle-celled sarcoma. The influence of the rays on the growth in this case may be taken as a fair example of the influence they have in any kind of malignant disease of the breast. You may take it as a fact that all embryonic tissue, whether carcinoma, epithelioma, sarcoma or rodent ulcer, is far more susceptible to X-rays than normal tissue, and this difference is so

marked that it is possible for a malignant tumour to disappear under the influence of X-rays while the skin covering it has not been affected. When the action of X-rays on the different varieties of malignant disease is compared, it appears that the more quickly a cell grows the more marked is the action of the rays on it, and the more quickly it passes off. Thus, to compare the two extremes—a rapidly growing sarcoma and a rodent ulcer—the same treatment produces a marked effect on the sarcoma in the way of relieving pain and tenderness, but it lasts a short time; while on a rodent the result is slight, but lasts a considerable time. From this it might be thought that a very malignant form of sarcoma would be easily cured, but practically the more slowly the tumour grows the better the result obtained, possibly because by the time a rapidly-growing tumour has come for X-ray treatment metastases have usually occurred in inaccessible parts. The microscopical appearance of the tumour seems to make little difference. A tumour well under the influence of X-rays will not give rise to metastases, but if the deeper part of a tumour is not being influenced this part may give rise to a spread of the disease.

In treating with X-rays it is necessary to remember that, like light and heat waves, their intensity diminishes with the square of the distance, and so it diminishes very rapidly. Further, the tissues themselves absorb a considerable amount of X-rays as they pass through them, so that at present the best results are obtained in those cases in which the growths are small and near the surface of the skin. If a sufficient amount of X-rays be given to stop the progress of a deep growth the skin will probably be burnt. Tumours, therefore, that are large or deeply seated are not very suitable for treatment. In the case of malignant disease of the breast, the secondary deposits are superficial, and it is only towards the end of the disease that the internal organs become affected, and for this reason it is particularly suitable for X-ray treatment.

I have recently seen two cases of growth of the upper jaw, both of which were growing very rapidly. The cheek was bulged out in each case, and there was both deep and superficial pain and tenderness. The result of treatment was that the superficial pain and tenderness cleared up and the patients were relieved, but in spite of this the tumours increased in size and the deep pain remained. This was because the X-rays had not penetrated to the deeper parts of the growth, but had affected only the superficial. I think that in the future it might possibly be found worth while to remove a so-called inoperable tumour of the breast so as to allow X-rays to reach the deeper parts of it, which could not otherwise be treated.

At the present time in the Light Department no two cases are treated in exactly the same way. A tube of equivalent spark gap of three inches is used, and three-tenths of a milliampère is run through the secondary circuit. The anode of the X-ray tube is kept 15 cm. from the skin. The length of time and frequency of the treatment is varied, and the time factor is a very important one. As an example, I will mention one case in which five minutes' treatment twice a week produced the smarting pain of the X-rays, while with three minutes twice a week the pricking pain of the cancer returned. When four minutes was given twice a week the result was satisfactory. By treating for three minutes three times a week through two thicknesses of lint, superficial growths become absorbed, and probably no signs of dermatitis will be produced, but as they are so likely to return, the patient, even if apparently cured, should always be kept under observation.

The Normal Arch and some Factors in the Aetiology of Dental Irregularity.

CLINICAL LECTURE BY Mr. J. B. PARFITT.

Gentlemen,—The title announced for this short lecture is "The Normal Arch and some Factors in the Ætiology of Dental Irregularity."

I may say at the outset that the causation of irregularity of the teeth is a very large subject, and I shall only touch the fringe of it.

The discussion of causation at any time is apt to lead us far; from the consideration of immediate causes we pass on to more remote, and further to more remote ones still, and so on "*ad infinitum*." We may, for instance, be inquiring why a tooth is in a certain position, and see that the immediate reason is that it was subjected during, and after, eruption to an excess, or it may be lack of pressure in a certain direction.

This again may have been due to some peculiarity of development. Development may introduce questions of parentage, and environment, and either of these may lead back from one cause to another until we came to the beginning of time. I intend to deal only with a few of the very immediate causes. The question of irregularity is intimately connected with that of the shaping of

the normal arch, in fact, they are not so much two questions as different aspects of one and the same.

Suppose we are examining the mouth of a child for the first time, and find some obvious irregularity which the child's parents may ask us to treat.

Unless we are going to work in the dark, there is a matter about which we must come to an immediate decision, namely, "If the child's teeth are not in their proper position, where exactly ought they to be?" I must confess that in some cases I find the answer to that question a rather difficult one, because the face of a child of, say, 8 or 9 years of age will still grow a great deal, whereas the teeth are already their full size from the first.

If the teeth are of large size, crowded together, and yet sufficiently prominent for the facial profile, one is naturally afraid that if they are arranged on a larger arch, they will cause an unpleasing appearance.

Dr. Angle gives two photographs of a case of this kind which are of great interest.

The first is that of a boy of 14. The teeth, after being regulated, appear to slant forward at a quite appreciable angle; the second was taken nearly two years later, and the tips of the teeth still occupied the same relative positions, but the facial growth had carried the roots outwards, so that the teeth occupied a quite normal position.

The older the child the more easy it is to decide on the ideal arch for his teeth.

The teeth in this ideal arch should conform to the proper standards, both of function and appearance.

In the first place, those of upper and lower arches must so occlude as to give the greatest efficiency for mastication.

Each tooth must have its mesio-distal diameter lying evenly on the arch; in other words, there should be no twisting of the tooth on its long axis.

In the position of the "resting bite" the cusps of upper and lower must interdegitate on both sides.

When biting "edge to edge," or on one side, there must still be some cusps touching at the back, or on the other side, so as to balance the force that is exerted in biting.

There must be plenty of room for the tongue.

Lastly, the teeth must be so in harmony with the rest of the features as to produce with them as pleasing a general appearance as possible. Naturally there have been attempts to discover what is the normal or ideal arch that shall fulfil all these conditions.

One of the most famous of these is due to Dr. Hawley, of Columbus. He recognised the important fact that the size of the arch depends on the size of the teeth, while the shape of it is determined by other factors altogether.

Dr. Hawley deduces the shape of the ideal arch for any case, by what is, I am afraid, rather an irrational geometric construction based on a measurement of the three anterior teeth of one side.

Arranged on this plan the six front teeth will lie on the circumference of a circle and occupy one third of it, or an arc of 120°.

The bicuspids and molars of each side will extend back from the canines in a straight line, inclined to the median line of the palate at an angle of 21°.

Apart from the difficulty of one or other of the teeth being possibly abnormal in size, as compared with the rest, I think the arms of this arch are too divergent. Nevertheless, it has the great merit of being based on the actual sizes of the teeth so far as they can be ascertained, and I think that if used intelligently and not in too slavish a manner, it might be a most useful guide in cases of difficulty.

We will suppose that, after giving due consideration to the sizes of the teeth, the articulation, and the facial profile, we have decided what we think is the correct arch for our patient.

In order to understand how it is that the teeth have deviated from their ideal arrangement, we must inquire what factors determine their positions in the mouths of those fortunate persons whose arches are of perfect form. These factors are—

1. The positions in which the teeth are developed inside the maxillæ and mandible respectively.

2. The force, whatever it is, that impels them to erupt.

3. The various lateral resistances that guide them into their positions.

4. The resistance that finally stops their erupting any further.

The teeth themselves have no influence on their course, they are perfectly passive instruments on which various forces are playing, and it is all one to them whether they go into the right position or anywhere else.

The factors which are involved in the production of the normal arch may with advantage be considered one by one.

The position of the teeth prior to eruption may be modified in several ways, either by disease or by abnormal development of the jaws, or even by accident or habit. The influence of over-development of the jaws carrying teeth far away from their ordinary position is well seen in those cases of superior protrusion, due to excessive development of the premaxillary bones, and of inferior protrusion due to over-growth of the mandible. (Some of Angle's, Class III., cases). The result of insufficient development may be seen in the contracted upper arch due to lack of growth of the maxillæ.

The causes of this may be either adenoids, or (as was pointed out in a very interesting article in the *British Medical Journal* a month or two back) it may be due to bottle feeding.

I know of two children of the same family, one fed naturally and the other on the bottle, and there is a most marked difference in the shapes and development of their palates, the naturally fed one having much the broader arch.

Some cases of open bite may be due to insufficient growth of the maxilla, or it may be of some part of the mandible, such as the ascending ramus.

To illustrate what may be caused by habit in disorganizing the dental arrangement as a whole, I have here models of a case showing the commencement of what Dr. Angle calls distal occlusion; it is evident that the lower jaw is biting too far back by the amount of about half a tooth; the teeth have accommodated themselves to this position, and it is therefore unlikely that Nature will be able to alter it without aid.

If left to itself this case will in all probability require, some day, expansion of one arch and jumping of the bite, by means of a Baker anchorage or some such device.

The abnormality in this case is almost certainly due to thumb-sucking persisted in until after the temporary teeth had come into their places. The child is well developed otherwise, and she has two older sisters, who neither of them have any abnormality of the teeth. The eruptive force of the teeth themselves is an all-important factor in the formation of the arch. This is especially seen when the force is insufficient, or too late in being manifested.

One sort of superior protrusion is almost certainly due to failure of the posterior teeth in erupting sufficiently to keep the lower incisors from biting the upper ones into a wrong position. On the other hand, it is possible that some cases of open bite may be due to excessive erupting of the molars.

The various lateral directing forces are, I think, the most interesting to us, because the irregularities due to excess, or lack of them, are the most common, and at the same time much easier to treat than those due to any fundamental error of development.

These forces may be considered as converging on any individual tooth from the four directions, labial, lingual, mesial, and distal. From the labial direction the tooth is subjected to the pressure of the lips and cheek, and in the case of the lower front teeth to the bite of the corresponding upper ones. Lingually is the pressure of the tongue, and on an upper front tooth the biting of the corresponding lower one against its lingual surface. Mesially and distally the tooth would be prevented from moving far by the resistance of the adjoining teeth.

It is worth noticing that diminution of either of these forces produces the same effect as excess of its opposing one; for instance, a tooth may take a lingual position either because labial force is excessive, or the lingual one too little.

Of these the labial may be considered the most constant.

An excess of labial force due to the tension of the cheeks has generally been considered to be one factor in producing the saddle-shaped upper arch often seen in mouth breathers. The lingual force may be in excess in some rare cases of enlargement of the tongue, but the tongue is probably much oftener deficient in size than we are aware, this deficiency being one contributing cause of general crowding of both arches, especially if there are gaps in them from loss of temporary teeth. An adventitious form of excessive force from the lingual side is found in tongue, thumb, or lip sucking, producing one sort of superior protrusion.

Most often, as a result of the habit of keeping the mouth open for breathing, the upper jaw in great part loses the support it ought to get from the pressure of the tongue, and this is probably the reason why contraction is much more common in the upper arch than the lower.

As a matter of fact, we find it is quite a common thing for the lower molar cusps to bite outside the upper ones, but it is very rare for the uppers to lie further out than they ought to be in relation to the lowers.

A most important case of deficiency of force from the lingual direction is that in which, owing to a deficiency of the lower arch, the upper one is diminished from lack of support of the lower front teeth.

The mesial and distal directing resistances are the most variable factors of all, and consequently the most fruitful causes of irregularities.

The ideal arrangement seems to be that each member of the permanent set shall erupt between two actual standing teeth, either two permanent, two temporary, or one temporary and one permanent.

If either of these is missing, there is a tendency for the incoming tooth to encroach on space not properly belonging to it. This leaves so much the less room for the next tooth when its turn comes to erupt, and if this is repeated several times there will be a serious diminution of the size of the arch, especially as we have seen that the labial pressure, or it may be lack of lingual support, constantly tends to close any gaps in it.

There is one class of laterally directed resistance that may act on any of the four directions, and that is the one caused by the pressure of a tooth, or part of a tooth, which is actually encroaching on the space required by the one that is erupting. This is an extremely common cause of irregularity, and the offending tooth may be either one of the permanent set, a supernumerary, or a retained temporary.

The last factor, the resistance that stops the eruption, may be considered to be the bite of the opposing tooth. One class of open bite is caused by interference with the normal stop to the eruption of the molar teeth. When, in the course of regulation, certain teeth have been capped, others are liable to grow too long, so that when the regulating device is abandoned the bite is found to be permanently propped open.

In conclusion, I may say that I do not pretend to have given an exhaustive list of irregularities, but rather a few samples to illustrate a certain method of inquiry into their causation. Inquiry on these lines will not carry us far, but is rather the first necessary step in the discovery of the deeper pathological causes which determine irregularities of the teeth.

A few Days around Lisbon.

"*What beauties doth Lisboa first unfold!*"—Byron.

Truly, the approach to Lisbon up the Tagus is the kind of vista to inspire poets. Since Byron's days, however, there naturally have been great changes. The "*fertile shores*" now show the marks of industry and modernity; nevertheless, the background of noble hills, with "Cintras mountain" o'ertopping all, seen by the fading light of a setting summer sun, which tones down the crudeness of the scattered tall brick chimneys and other signs of the march of industry, is still a sight to bring exclamations of admiration from the lips of the tourist. The panorama presented by Lisbon itself is infinitely better than anything one can find in the town. The promise of hidden treasures, as imagined by the view from afar, is soon lost. One finds that the white houses piled one above the other and rising to the summit of the several hills on which Lisbon is built, are, on closer acquaintance, plain lank giants separated by streets of medieval width, and surrounded by a general environment of evil odours and conditions which would make a primitive Balkan village envious. No, Lisbon from a distance is a feast of colour and splendour; take your impressions from there. Its white and terra-cotta coloured buildings, the green waters of the river, the crowds of small craft with their multi-coloured sails, the women on the quays in their bright red shawls and head-handkerchiefs, all lend to the scene a gaiety which is indeed refreshing to the eye of one whose vistas for some time previously have not extended much beyond the grim greyness of solid old London.

There are many things of interest to be seen in the town. One is immediately struck by the Praca do Commercio, or Roly-Poly Square, as it is called by our sailors. It is paved with pebbles, arranged in a geometrical pattern of such a kind that they seem to be undulating. I was assured by an Englishman in residence there that the effect on one, after a too liberal dinner—when the liquid part has been especially well seen after — is positively terrifying, something like ascending a moving staircase backwards.

Of the churches, St. Roche is well worth a visit; its mosaics are reported to have cost over £6,000,000. Passing on, one comes upon the Avenida, a broad thoroughfare, something between our Rotten Row and the Avenue de Bois, in Paris. This is the fashionable parade, and on certain days it is most picturesque, with its crowd of "promeneurs," cavaliers, and carriages. The Botanical Gardens, easy of access, are worth going to, for, apart from its marvellous collection of palms and extremely tropical appearance, one can obtain an excellent bird's-eye view of the city.

Belem, a suburb reached by tramway—the tramway system, by the way, is admirable—contains a building which for interest eclipses anything to be seen in Lisbon itself. This is the Church and Convent of Belem, which was founded in 1500 by Manuel the Fortunate. This was the period when Portugal's power was at its zenith, the age of naval enterprise. Its architecture is a strange medley, Gothic, Moorish and Romanesque work overlap one another. The cloisters are magnificent, the stone work therein being exquisite. At present it is used as an orphanage, and is overrun by the happy little denizens.

Another tram-ride takes one to Cascaes, a sea-side place, which of late has shown much development.

One's next excursion should be to Cintra the Glorious. It is as worthy to-day of the ardent praise which Byron poured upon this veritable Eden, as it was then. Unspoilt by the encroachment of the builder, Cintra will afford one unlimited pleasure. Its "*variegated maze of mount and glen*," its glorious panoramas and the marvels of the famous Garden of Montserrat will tempt the traveller to rest and forget the worries and strife of the world outside. In the village itself—it is distant about twelve miles from Lisbon—there is to be seen the Palace of the Dowager Queen. It is a Moorish edifice. One thing that strikes the visitor is the peculiar large round chimney which arises as a dome from a capacious room that once served as a kitchen. On the top of a high crag which overhangs the village is the remains of an old Moorish citadel. The view from the still intact walls is magnificent; on a fine day the famous Lines of Torres Vedras may be seen.

On a similar hill, not far distant, rises the Pena Palace. This is the summer residence of the Royal family. On certain days it may be inspected on applying for admission. The drive up to this castle is a steady climb up a zig-zag track through most beautifully-wooded country, where one sees verdure of every tint, from that of the "*imbrowned mountain-moss*" to the vivid green of the young vine. It is the custom to "do" it on a donkey; these sure-footed animals have a strength which one would not imagine from their diminutive stature. Another drive to the ruins of the Cork Convent, where once dwelt the good St. Honorius, is a thing of wonder. Ever-changing panorama unfold at every turn; on one side is a maze of verdant glens, on another, crag after crag surmounted by cork trees give a sombre aspect to the view; then another turn, and below one sees green pasture land with the ocean rolling in the distance. On the way back a call can be made at Montserrat. This beautiful estate, the property of Sir F. Cook, is a series of vales each more amazing than the other. It is a natural botanical gardens; plants and trees of every clime find therein a place. Here a group of New Zealand tree-ferns grow beside a pond covered with brilliant water-lilies; here an aloe raises high its spike-like arm; here an old-fashioned rose-garden; here a grove of orange trees, and so one passes along paths from wonder to wonder. On the way back to the village the palace, wherein was signed the famous—or rather infamous—Convention of Cintra, is passed.

Indeed, one could spend many weeks in this glorious spot, and, after all, it is not very far from England. If a voyage is contemplatod, do not forget its charms. Childe Harold found it an Eden, and it has lost nothing in the passage of time. Again, there are other beauty spots in this land of Lusitania, Busaco, and Leria. Yes. Portugal is well worth a visit!

A. V.

Notes of a Roving Guy's Man.*

VI.

ONE cannot leave Berlin finally without a reference to Prof. Kraus' excellent clinics, given at the second medical clinic in the Charité. Not having come to Berlin to attend purely medical lectures, I allowed weeks to pass without an attempt to "put in" Prof. Kraus' seven-thirty morning class, though I made a point of going to hear Senator and His. To some extent this avoidance to the second medical clinic was due to the fact that one heard so much about it, and I have learned to rate very low the medical lecturer whom the average student declares to be a perfect gem. "Oh, you really must hear Kraus," was the remark thrown at me by almost every colleague I met, whether at a clinical or at a bridge party. "Just hear him once, and then come away, for it won't be worth while going every day." When at last a colleague who had had the privilege of listening to that most fascinating of medical lecturers —now, alas, lecturing no longer!—Sir Henry Littlejohn, joined the chorus of admirers I thought it might be worth while to look in one morning. So one day, when a longer stay with the "experimental animals" had made it too late for me to attend a surgical clinic, I joined forces with the Scotch colleague, and took a seat high up on the benches of the second medical Hörsaal. The professor, who in appearance and manner slightly suggests Dr. Horrocks, entered almost immediately afterwards, bowed with a cheery "Good morning, gentlemen," and, to my disgust, began with a remark about the Becker-Lanhoff index. "Hang it, he'll go on to opsonins or some other trash, and I shall have wasted an hour," I whispered to my Scotch friend, to be reproved by a reverential "Sh—ss." Not being the least interested in the Becker-Lanhoff index, I took a mental note of the audience, which, like Bier's, was cosmopolitan to a degree unknown in London or Paris. There on the bottom row were a lot of American men—C——, from South Dakota, and M——, from Montreal; on the second bench was an old gentleman, a Roumanian army surgeon, alongside of three Greeks; on the third, a row of Russian students; higher up, a Pole, recognisable by his rank locks and his expansive silk tie; on the left, two Danes; on the bench just below mine, three Japanese; close by, a Chinaman, who speaks the most perfect English with the queerest intonation imaginable; here again a Portuguese doctor; there a lady doctor from Switzerland. Every country and every medical faculty in Europe, almost, one would see here, and the number of outsiders really exceeded that of the regular students. The professor spoke quietly, with a marked Bohemian accent, which is to German somewhat as Yorkshire is to English, and used his hands effectively. Bit by bit I got interested, and after the first quarter of an hour I had become an admirer. It is difficult to say wherein lies Kraus' charm. Like the two other great medical lecturers I have had the good fortune to hear, Sir Henry Littlejohn and Dieulafoy, his main subject is always an ordinary one, not an exceptionally rare case or disease, and like them he contrives to enrich his lecture with a host of recollections and remarks which are illuminative and interesting. In each of these three great lecturers their force to attract and fix the hearer's attention lies in their ability to portray in an intensely dramatic fashion the subjective side of their cases. When Dieulafoy tells his class of the "auro-temporal pain" which the patient with carcinoma of the floor of the mouth suffers from, you almost feel the twinges yourself; just as when Littlejohn described his one great mistake (if one may be permitted to call it so), one saw the whole trial before one's eyes, the skulls on which the shooting experiments were made and the long array of contradictory witnesses. So, too, with Kraus. To take down verbatim his lecture would give but a poor idea of what it is like; it is the gesture that counts, the particular stress on a word here and there, the peculiar charm in presenting the whole. I never thought the Becker-Lanhoff index and its vagaries would entrance me, but they did—when Kraus handled them. And then his manner! You must see it and meet the man personally to appreciate it correctly. With what fatherly benignity he addresses the patient with a failing heart. "My dear little child" (the woman is thirty), "you must come into hospital, and then you will sooner get well—much sooner, I can promise you." With how much good nature, tempered by a twinge of irony, does he turn the students inside out. It is a heart case again, and three gentlemen are called down to examine it. "Listen there," he says, and they put their ears to the spot. (I am afraid Kraus would smile when he saw us all depending on our binaurals.) "Now, you, what is it?" "A systolic bruit, Mr. Professor." "And you?" "Systolic." "You?" "Presystolic—at least, I think so." "Ah, you are cautious, you third. But you are all wrong, gentlemen. There is no bruit there." Then another case, this time a most interesting Langenbeck's tumour. "What is the matter with the patient's eyes, sir?" he asks No. 1. "Ptosis, herr Professor." "Right, and what nerve is affected?" "The second, sir." "And you?" turning to No. 2. "The third, sir." "And you,"—turning to No. 3—"do you agree in consultation with these two opinions expressed by your colleagues?" "It's the fourth, sir." "Ah, gentlemen, gentlemen, how often must I reiterate that a physician without a good knowledge of anatomy is like a captain of a ship without a knowledge of navigation? Believe me, anatomy's not only for the surgeon. You may make up your own little systems and theories in physiology as you go along, but you must know your anatomy. Your physiological theories may be as good as those you were taught, but your shots at anatomy will never hit the mark. Now you,"—to No. 1—"if I were to cut your second cranial nerve, do you really imagine you would

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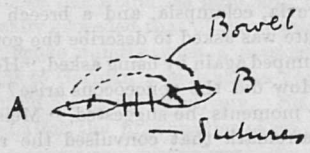
get ptosis? No, of course not. Nor you"—turning to No. 3—"if I cut your fourth nerve. You, sir,"—to No. 2—"have answered correctly, and I will reward you. You may feel inside the patient's mouth and tell us what you find." No. 2 at once thrusts his fingers into the patient's mouth, but the professor draws back his arm. "Never feel like that, my boy. Bear in mind that you are not investigating a phantom, but a sensitive person. And, gentlemen, let me ask you to remember always that your patient is usually more sensitive than a normal individual, and that in all your examinations you must use the utmost gentleness. Now, my little son" (this to the patient), "the doctor will feel in your throat and you must breathe quietly. It will not harm you, and it will enable us to find out what is the matter with you." The tumour, projecting downwards through the posterior nares, is easily felt, and the professor gives a lucid and most interesting lecture on the case. On the three occasions I visited the clinic I was fortunate enough to find cases which were as much surgical as medical—this Langenbeck's tumour, acromegaly, and tubercle of the larynx. No one visiting Berlin should refrain from attending Dr. Kraus' classes. He will find the lectures as interesting and as useful as any in Berlin, and he will also find the lecturer a broad-minded, liberal gentleman, whose standard of conduct is not regulated by the narrow code prescribed by the American Medical Association. In one of his lectures I heard Kraus refer to the homœopathic treatment of heart disease, and the reference was greeted with a derisive laugh by the class. "Ah, gentlemen," he said smilingly, "when you are as old as I am you will have found out that it does not do to laugh at these things. When you meet a homœopathic colleague in consultation—and there is no loss to you in doing so—you must at least know something of his methods." Another interesting place in Berlin is the Morgue, where Prof. Strassmann gives his lectures on medical jurisprudence. The Morgue itself, which is public, as the old Paris institution used to be, possesses a fine museum, and there is always sufficient material for practical demonstration, while students who desire to do special work in some branch of medico-legal work will always find the professor, a genial, joke-loving individual, eager to help them. The lectures are given in a small hall adorned with busts of Casper, Liman, and other great medico-jurisprudents, and are always interesting, being illustrated with many specimens, photographs, and personal reminiscences which the professor selects from his varied store acquired through an unusually lengthy and interesting career. Yet a third place of interest is the huge university anatomical department, where the student can get a part for dissection at a very low figure. The dissecting rooms, although not so fine as at Brussels and Munich, are large and well ventilated, and the bodies are all very good. Prof. Virchow (the son of the great pathologist) is in charge. He is an enthusiast, and gives each student an amount of individual attention which one would hardly expect where so many students are at work. During the summer months no regular dissecting is done, and only the room devoted to regional anatomy is in use. Here the senior students work on special parts, and it is exceedingly helpful to run in and spend a half-hour going over the parts. The professor does not mind, "so long as you don't disturb the gentlemen, and take care to cover the parts afterwards," and as several friends were dissecting parts, I frequently availed myself of the opportunities. A particularly fine body is kept for demonstration of muscles, and many of the regional specimens are so fine and well done that it is a pleasure to look over them. The veterinary school is close at hand, but I had only time to visit the "Dog Out-Patients," where numerous pets are daily being treated very much as usual out-patients are treated with us—bandaged, splinted, prescribed for, X-rayed, and so on.

Close to the Charité is the Kaiserin Friedrich Haus, which is the Medical Graduates' Palace at Berlin, and which every stranger coming to the city should visit. Here Prof. Kuttner, the director, will give all information regarding courses and practical work to qualified men who wish to study in Germany, and here, too, is an excellent museum, containing the late Prof. Lassar's collection of wax models, in some respects superior to our own, and Prof. Höllander's unique collection of medico-historical objects. Among the latter are many of great interest to English students. This Kaiserin Friedrich Haus is one of the most interesting institutions in Berlin, and one can only hope that, in the near future, London may possess something like it.

My last visit to the Charité was to Bumm's clinic, to bid farewell to the Geheimrat. I found him engaged in viva-ing a student up for his final, and as the examinations take place in public I had the opportunity of contrasting the process with our own. The subject was, of course, gynæcology, and the questions were throughout practical, with here and there some theory. Thus, the Geheimrat gave the candidate a placenta with a knot in the cord. "How was that formed?" "What varieties of knots may occur in the cord?" "Is it possible for a surgical knot to occur?" "How does the child tie the knot?" This last question stumped the candidate. He was given a bandage and told to hold the ends in each hand, and then to tie the knot without letting go the ends. After a minute's wriggling about he declared it was impossible. "Oh, dear me, no! It's the easiest thing in the world—when you know it," said the Geheimrat, and tied the knot in a twinkling. I leave the method for some enthusiastic extern to find out, only adding that it is really easy once you know the trick. The further questions were on gonorrhœa, and on placenta previa, eclampsia, and a breech presentation. The candidate was asked to describe the gonococcus, and then was stumped again by being asked, "How had it been evolved? How did the gonococcus arise?" After hesitating a few moments, he suggested, "Meissner had the first one," a remark that convulsed the room. In the case of eclampsia he was frowned down when he suggested

opium in the treatment. I may mention that the Geheimrat had a case of coma following eclampsia, in which the usual treatment had been entirely unsuccessful, and had declared his intention of extirpating the ovaries and tubes on the suggestion that the real cause was ovarian secretion. The operation was, I believe, carried out, but as I left Berlin that day I have not heard with what result. The viva was, of course, only a small part of the examination, which lasts several weeks, the candidate being required to do certain operations in front of the class. Thus I saw one man do a perforation with scissors. He extracted the child, which commenced to gasp and struggle on the table, thus giving the Geheimrat an excellent opportunity for pointing out the inconveniences which might result in private practice if a perforation was not done systematically. "For you," he said, addressing the candidate with a smile, "I should advise having a bucket of water handy next time, into which you can drown the infant as soon as you've got it out." And then, when the general laugh had subsided, he went on, "Seriously, it is not pleasant to hear a dead child cry out. You know it is dead, but the relatives and friends do not. And again," with a malicious twinkle in his eyes, "there's the legal question for you to consider. You have extracted a living child, and it is now your duty to try and preserve its life. Therefore, you must suture up the skull, dress it aseptically, and take every care of it!"

The same morning I went for the last time to listen to Prof. Hildebrand, whose clinics I had neglected somewhat in order to attend Bier's. Hildebrand is the conservative man—you attend his lectures to find out where surgery pauses. Some people say it is no use attending them, for they make one so terribly pessimistic, yet it is well worth while seeing bad results and failures, and not always merely to witness brilliant surgery without having a chance of seeing its after-results. Thus, on my last visit, the professor demonstrated a series of very bad cancer cases. One was a woman whose right breast had been removed for carcinoma eleven years ago. Now she had a growth in the old scar, a small mass of growth in the upper and inner quadrant of the left breast, and hard glands on the right side above the clavicle. The next was a case of double carcinoma mammæ, another a "recurrence" after extirpation of the tongue two years ago, and a fourth a recurrence after extirpation of an anal cancer. In the last a colostomy was done in a very simple manner. The wound was made in the usual situation, oval in shape, and an inch longer than usual, the bowel pulled out, and a bridge sutured underneath the loop, the appearance of the wound being somewhat like this:—



The peritoneum of the loop of bowel was not sewn at all. As soon as natural adhesions had formed at A and B, the bowel was opened with the thermocautery, two openings being thus made, of which the proximal one, at B, is the artificial anus. The operation is simple and easy to carry out and gives good results, though it may possibly be more difficult to close such a wound afterwards. In this case, of course, ultimate closure was not contemplated. Hildebrand's lectures are very useful, because he draws so largely upon his own experience, and so frankly tells you the results of operations, and also because, unlike Prof. Bier, he goes very fully into questions of differential diagnosis and alternative methods of treatment.

After Berlin, Leipsig, which is rapidly rising as a medical school, is rather tame, although it rivals the capital in the number of students and in the completeness and up-to-dateness of its institutions. The largest medical school in Germany is, after all, Munich, though it is not by any means the best. At Munich there are far too many students for the amount of material and for the comparatively small staff of teachers. The foreign element in Munich is also relatively larger than at Berlin, and there is a tendency—which is much more pronounced in Vienna—of regarding the English practitioner who comes to learn new methods as a sort of ignoramus to whom elementary essentials are unknown. To some extent this is the fault of the students themselves. Many of them go to Munich without the slightest knowledge of the language and attend demonstrations and classes which are utterly elementary. The privat docenten and professors naturally are somewhat astonished when the stranger expresses his admiration of a course which is by no means out of the ordinary, and, perhaps equally naturally, there is some difficulty in obtaining such courses as at Berlin. "The Englishman comes here," I have been told, "and imagines he can obtain everything he wants from us in six months. Then he writes a paper." At Leipsig comparatively few outsiders are to be found as yet, though, from a surgical point of view at least, it is in many ways better than the Bavarian University. The clinics are large and excellent, the material is rich (at no other place, except Cologne, can one see so many cases of fracture or study this side of surgery so well as at Leipsig), and the lectures are, almost without exception, good. Extra courses can always be obtained by special arrangement with the heads of the various clinics, and though I have no personal experience of these, I am told by those who have taken them that they are fully equal to those that can be obtained at Berlin. The medical student will naturally wander first into Prof. Flechsig's clinic where he can see a large number of interesting nervous and psychiatrical cases, or to Prof. Curschmann's lectures on general medicine. The surgical student will find most to occupy him at Prof. Trendelenburg's surgical classes, and at Prof. Marchand's lectures on surgical pathology. My own time was chiefly occupied at Prof. Kölliker's clinic in orthopædic surgery, with an occasional

visit to the chief surgical clinic. At Trendelenburg's clinic the student is impressed with the up-to-dateness of everything. There seems to be no stinting anywhere, and the instrument cupboards are filled with a variety of new and strange things which one can spend a day in examining. Not all of the novelties I saw appeared to be excellent, and, as has been the case at Breslau, where Prof. Mikulicz invented a score or more of new instruments, I should imagine that in a few years many of these new-fangled and in some respects complicated helps to surgery will be discarded in favour of older and more simple ones. Thus, there is a large automatic retractor for abdominal work, unnecessarily complicated with screws and nuts and flanges; there are many varieties of tracheal canulæ, ranging from the T-shaped to curiously-bent instruments used after tracheo- and laryngo- plasty, while the armamentarium for lung operations is one of the most complete in Germany. Among the newer instruments designed for lung work are fine-bladed, very long extraction forceps, blunt lung retractors and gridiron lung compressors. Some very excellent models of modifications of our usual instruments are to be found in the Trendelenburg clinic, and I was particularly impressed with the large blunt retractors for abdominal work. These are made of thin copper, covered with china silver, and can be bent into any requisite shape: they are strong, serviceable, and appear to be just the kind of thing wanted, as they can be had in all sizes. Another fine instrument is the Whitehead mouth speculum with a Helbing's tongue depressor attached: this is really an efficient gag and a most useful instrument for mouth operations on children. The speculum acts as a good gag, and the tongue depressor, which acts automatically, keeps the child's tongue firmly under control. In the orthopædic department the instruments are equally fine. I noted for future reference the thin epiphysiotomy chisels with T-shaped handles, the pliable sequestrum forceps, and the very strong and serviceable bone forceps used for wiring bones. This last is one of the best models I have yet seen, giving a strong grip with excellent leverage.

A résumé of the work at the orthopædic department here would scarcely interest the majority of readers, though the department is really excellent, and one sees many good cases. In the main the treatment is very similar to that which is followed at Berlin and Hamburg. I saw several cases of fractured neck of the femur treated by Bardenheuer's method, in which longitudinal extension is combined with "rotation extension." The leg is sometimes put in what is known as the "Morisiani position," that is, strongly abducted while extension is being made, as it is said that the ultimate shortening is greatly reduced when that position is adopted. The Beeley suspension method—a modification of our Hodgen—is also used, but Volkmann's extension (practically Hamilton's method) is favoured, and gives very excellent results. The division between intra and extra capsular fractures is not kept clearly in view in the wards, all cases being classed as fractures of the femoral neck, though a skiagram is taken as a matter of routine. The teaching here, as at Berlin, is that in a case of intracapsular fracture, shortening may be very great owing to stretching of the capsule, and that in badly impacted cases disimpaction is always desirable. In children fractures of the neck seem to be more common than with us. They are treated by strongly abducting the leg and extending on a long splint. Where the shaft is fractured, the suspension method is usually made use of. Wiring for uncomplicated fractures is generally condemned, it being stated that with proper care ordinary treatment is usually quite sufficient, whereas wiring, even in the best hands, sometimes leads to unfortunate after-effects. Where the epiphysis is directly implicated, wiring is looked upon more favourably, but even here customary treatment gives very excellent results. The photographs I have seen of cases treated by conservative methods certainly do not show results much inferior to those treated by operation. It is, of course, easy to pick out a series of conservative cases with bad results, but it would be just as easy to give a series of equally indifferent results after the open operation. That in both cases the bad position is in the main corrected after a time, cannot be much doubted. Thus in nerve suturing operations, where the von Hacker method was employed, a great deal of deformity resulted in one patient owing to the splints slipping, but all this was corrected in course of time. At out-patients, both here and at Breslau, I saw some interesting "foot cases." The first was a milkman, who had fallen and limped into the room dragging his left foot behind him. He could not stand on the foot unsupported, but did not complain of much pain or tenderness, and the only abnormality I could find was some swelling over the dorsum, and slight tenderness when the toes were forcibly extended, such tenderness being chiefly in the region of Lisfranc's joint. The second case was that of a boy who had jumped from a spring-board in a swimming school. He also limped, could not bear his weight on the foot, and had some swelling. The third was a waiter who had fallen and twisted his ankle; his condition, too, agreed very closely with that of the others. I thought that they were all cases of wrenched foot, with some straining of the ligaments, but each case, when skiagraphed, turned out to be a beautiful transverse fracture of the four outer metacarpals almost directly in the middle. This lesion is said to be very common, especially in soldiers. After a long march the young recruits' feet get tired, and the weakening of the plantar muscles allow the metacarpals to become exposed to any sudden strain or shock. When at the end of the march, therefore, the sudden command "attention" is given, and each man stamps his feet heavily on the ground in the approved German regimental fashion, the violence is directly transferred to the metatarsals, which snap across at their weakest point, practically in the middle of the bone. The line of fracture is usually obliquely transverse, running outwards and backwards, and the first metatarsal usually escapes. Very often the lesion is bilateral, though the right foot is usually involved. Unless skiagraphed, such cases, owing to the comparatively few subjective and objective signs,

are taken for sprains and treated as such, often with bad results, as flat-foot, pressure, pain and other defects may follow. When correctly diagnosed—and after one has seen a few cases, the diagnosis presents no great difficulty—they are easy to treat by means of a flat metatarsal splint, and a week's rest. Another very interesting foot condition, which with us is certainly not so common as it appears to be here, is what one may class generally under the heading of "foot pain." I have been somewhat interested in such cases, as I have hitherto taken the majority of them to be purely hysterical. Thus, when travelling to Königsberg, my carriage companion, an old army officer who had been vigorously fighting the Schleswig-Holstein war over again for my benefit, suddenly jumped up without any apparent cause and began hopping about the carriage on one leg, uttering the most frightful and the most undignified objurgations, the while

Cussin' 'is Maker, an' callin' things orful.

On my astonished inquiry "*was ist denn los?*" he calmed down and said, "It's my cursed foot again." A close examination of the offending foot revealed absolutely nothing—not even the usual lowering of the arch one finds in old men whose occupation entails much standing, and I put down my old officer as an arrant humbug. I think I owe him an apology, for since then I have come across many other cases similar to his, ranging from the simple metatarsalgia described by Morton, to the violent paroxysmal neuralgic pains which seem to radiate along the sole of the foot, and for which no cause can be discovered. The majority of patients I have seen—I have notes of twenty-four so far—are patients attending private clinics, and therefore of a better class than hospital outpatients. In each, one can exclude any palpable or visible defect of the foot, such as flattening of the arches, with its well-known pain over the dorsum and in the heel, or "spurred heel," where an exostosis of the os calcis causes pain by direct pressure, or cicatricial contraction, obvious bony thickening, inflammatory condition, or deformity. The patients range from 10 years to 62, the average being roughly about 30, and none of them can be said to stand or walk excessively. In the majority of cases the pain is exceedingly severe, not definitely localised over one metatarsal, as Morton described it, but affecting the four outer bones of the foot. It is paroxysmal, and may come on (as in the case of my old officer) while the patient is resting his feet; thus, there cannot be in every case a sudden twisting of the projecting base of the fifth metatarsal. The pain due to this latter cause we have all of us felt at one time or other; it is usually an inconvenience more than an agony, and only lasts for a few seconds after the pressure which produces it has been removed. These other cases of metatarsalgia, or Morton's foot (though the condition is not quite the same as that described by Morton) seem to depend on something more than mere flat foot. Here the explanation is that in each case there is a deformity of the anterior transverse arch, permitting the bases of the metatarsals to descend lower, and thus causing pressure upon the plantar nerves. In all cases great care is taken to exclude ordinary causes—chiefly slight flat foot or valgus—and the patient is given a celluloid "inset" or boot brace, which usually suffices to relieve him of his pains. In a few cases, however, this treatment has not had any effect. Excision or operation is discountenanced. It may be that some of these cases are due to old fractures of the metatarsals such as I have described above, or to some malformation in the bones of the foot, or that in some few cases they are really hysterical pains, but the majority seem to be due to some as yet unknown cause. Osteoarthritis of the foot and pure tarsal neuralgia, both of which have been invoked as explanations, do not seem to be probable causes in any of these cases, and one must leave the matter as unexplained as those interesting cases of paroxysmal patella pains, described by Riedle, in young cavalry officers.

Another interesting condition I met with was multiple periodic intermittent hydrops articuli (one has to apologise for the name!). The patient was a woman who has suffered from the affection for many years, and has been to many bathing places, hydropathic institutions and private clinics without much benefit, except in so far that she has learned quite a host of theories which explain her affection. Regularly twice a month her joints—knee, shoulder, elbow, fingers and ankle—become swollen and filled with clear fluid. There is no pain and no sign of inflammation, and the bursæ are not apparently affected, and there does not appear to be any constitutional disturbance, though while the joints are swollen she is not able to walk about owing to the weakening produced by the swellings. No theory seems to explain this condition satisfactorily; probably the most reasonable one is that the affection is due to some parasite which has definite periodic changes like the malarial hæmatozoon. Nothing so far has had the slightest effect upon the condition, though the patient has tried every suggestion made by her numerous advisers. Systematic washing out of the affected joints with iodine or carbolic lotions cannot be tried on all joints, and in the case of one knee-joint it was only temporarily successful.

At Trendelenburg's clinic the great novelty is, of course, the chief's operation for pulmonary embolism. The instruments for the emergency, which is now eagerly awaited, are kept ready sterilised in each ward, and so far the operation has been twice performed. The first case was that of the chief himself, of which details have already been published. The other was operated upon by Dr. Sevier, Trendelenburg's first assistant. The patient was a middle-aged woman who was admitted for obscure abdominal symptoms, diagnosed as appendicitis. She was kept under observation, and appeared to be doing well, when, about eight days after admission, she was suddenly seized with symptoms pointing to obstruction of the pulmonary circulation. When Dr. Sevier arrived by her bedside he found her moribund, no respiratory movements being visible. The operation was

done at once, and two large emboli, which are now proudly preserved, were hooked out of the pulmonary artery. The operation took place at daybreak, and immediately upon removal of the clots the patient began to recover, breathing slowly at first and afterwards more rapidly. The wound was sutured and closed successfully, and the patient put back to bed. She recovered consciousness, and in the afternoon there appeared every probability that she would do well. Unfortunately, late in the evening of the same day her condition changed for the worse, and every effort proved ineffectual to keep her going, death following eighteen hours after the operation. Full details of the case, with the post-mortem findings, will be published in due course, but one may take it that the operation itself was successful in so far that it resuscitated a moribund patient. Time only can show whether patients in such a condition are able to cope successfully with the grave shock caused by such a severe operation, which appears to be justifiable when one considers how impossible it is in surgical practice to guard against this fatal complication. That pulmonary embolism is not a rarity with us, Mr. Anderson's summary of the cases in Bright, published some years ago in the GAZETTE, shows very well, and in large surgical clinics, such as here and at Berlin, it is necessarily relatively more frequent.

The treatment of enlarged prostate is an interesting subject to discuss, and, having had frequent opportunities of seeing cases treated at the large continental hospitals, I may, perhaps, be allowed to jot down a few points about it here. In England, for example, I never witnessed the old operation of vasectomy, which I saw here on several occasions, though, as with us, prostatectomy, either by the perineal or supra-pubic route, is usually done. The first supra-pubic prostatectomy in Germany was done by Mikulicz, at Breslau, after his return from his American trip, and at Bier's clinic it is still the favourite operation. One of my points noted down for reference was to ask Prof. Bier what the results of his own operation—ligature of the internal iliac—had been, but the matter slipped out of my mind, and I did not discuss it, though I saw the Geheimrat do a complete enucleation in a business-like and thorough manner, and also saw him demonstrate the almost forgotten Bottini's method. My main interest, however, lay in the vasectomy results. I have in mind a patient who for many years suffered much from retention and the usual concomitant troubles which afflict the man with an enlarged prostate. This gentleman was completely subject to his catheter, and was operated upon by Mr. Butlin some ten years ago, both vasa being tied, with the best results. He no longer uses a catheter, but lives an active life (for his age), and declares himself a new man. This case made a great impression on me. The operation is so simple, and in this case it proved so successful, that I could not but wonder that it has been so generally discarded with us in favour of the much more severe complete enucleation. Thus Mr. Wallace, in his recent book, dismisses vasectomy almost contemptuously. Tying both vasa of a sheep or dog produces no atrophy of the prostate in these animals. I cannot see the logic of such reasoning. If it can be proved that vasectomy done on an animal with a pathologically enlarged prostate has no effect in diminishing the size of the organ, then there might be some point in the argument, though even then such cases as that of Mr. Butlin's patient will have to be explained. But to argue that because vasectomy does not cause a shrinking of normal prostatic tissue, and is therefore unable to cause a diminution in the size of a pathologically altered prostate, appears to me to be worse than what Father Fuller styled "the logic of Tenterden steeple." Nor have continental surgeons generally discarded vasectomy. Thus Rovsing states that he does it as a routine operation in all suitable cases. If it has no effect, there is always enucleation to fall back upon. The older operation of White is rightly condemned as useless and dangerous. Wood's paper, which is often quoted against vasectomy, puts the mortality of this operation relatively high—I believe as high as 7 per cent.—and Mr. Freyer, as is natural in a supporter of enucleation, favours the complete abandonment of the operation, but it is surely worth while to tabulate the cases once more, taking in those done on the continent, and to admit the operation as a legitimate one in certain cases. That secondary operations on the prostate are often required, no one denies; Rovsing himself does many, and his mortality figure after vasectomy is certainly not anything like 7 per cent., while, again, the mortality after enucleation operations here is somewhat above Mr. Freyer's low figure—7·5 per cent. White's operation has a mortality of nearly 18 per cent., and its after-effects are such as to make it the last operation that the surgeon should resort to. But vasectomy as used here, that is, as a trial preliminary, which may do much good, and, in good hands, can do little harm, seems useful and justifiable. I have seen other cases as excellent as that of Mr. Butlin, and also others in which no great permanent benefit has resulted. Whether, in the one class, the vas alone was tied, while in the others the sympathetic nerves were included in the ligature, it would be difficult to determine. One point, perhaps, may have some bearing on the good results obtained in certain cases, and that is, the strict attention which patients have paid to their health afterwards, and the regular use of a catheter for some time after the operation. At the German clinics vasectomy is still done, but enucleation, because it gives more permanent results, and because it is being vigorously championed, is steadily gaining ground.

Taking cases generally, it appears that enlarged prostate is somewhat less common here than with us. At Leipsig the percentage to all cases admitted is very low; at Breslau and Cracow still lower. Equally infrequent, in out-patient practice at least, appears to be prostatitis. On the other hand, cystitis and general urino-genital conditions are certainly as frequent as with us. A somewhat unfamiliar phase of an old complaint is "ureteritis." This is a condition in which the patient complains of

vague pains, referred to the penis or pubic region. Cystoscopically little can be made out beyond, perhaps, some turgidity of one uretral orifice. At a course in cystoscopy which I attended, several such cases were cystoscoped, and we all took the condition to be one of commencing tubercle. This, however, is not the case. The urine is free from tubercle bacilli, and such patients do not usually give a Pirquet reaction (the more uncertain Calmette's ophthalmo reaction has been entirely given up here), and usually get quite well under proper treatment. The slight hæmaturia and the pain make them seek advice, and the condition is thus diagnosed by exclusion of other and more grave affections, such as stone, or tubercle, or new growth. The primary condition is one of transient inflammation of the mucosa of the ureter. This may extend downwards or upwards. Thus, in cases of Maydl's operation, in which there is usually some kinking of the ureters, the patients practically get a chronic ureteritis if they survive long enough. So, too, after direct catheterisation of the ureters, or after bad cystoscopy. Examinations by means of the cystoscope are done admirably here—far better than I have ever seen them done at Guy's. So, too, proctoscopy, œsophagoscopy and urethroscopy. This is due to the fact that the men have so many opportunities for perfecting themselves in the handling of the instruments. At a class, for example, the men pass the instruments themselves and make the diagnosis after having seen a fair number of normal bladders. With us this is not the case, to judge from the fuss and excitement which prevail when a cystoscopy is done and the length of time the instrument is retained in the bladder. In the hands of a practised operator a cystoscopic examination lasts only a short time, no anæsthetic is required or given, and the patient lies comfortably down, his attention being distracted by one of the assistants. When ureteral catheterisation is required, more time is, of course, taken, but even here it is surprising to see how quickly and expertly the operator does his job. All this dexterity is the result of much practice, both on normal individuals, on excellently made "dummies," and on patients, and the first thing that strikes one is the fact that all the manipulations are done so gently and with so little disturbance to the patient. One of the last operations I saw at Guy's was the passing of a sigmoidoscope, and the picture of it—the patient groaning heavily, the operator struggling valiantly in all sorts of impossible positions, and the assistants perspiring at the bellows—was in striking contrast to the one I saw here, a sigmoidoscopy done by an assistant for an examination of rectal cancer. In this latter case the patient was propped up comfortably, talking all the while, the tube was quickly, but gently, passed, and the operator as well as the assistants had a clear and excellent view of the field.

C. L. L.

Vienna, June, 1908.

Papers by Guy's Men.

Malignant Disease of the Stomach associated with Malignant Disease of the Glands Above and Behind the Inner Extremity of Each Clavicle. By Henry Morris, M.A., M.B., F.R.C.S. Eng.—*The Lancet*, 15th August, 1908.

The Treatment of Carbuncles, Boils, etc. By J. Reynolds, M.D., and Russell J. Reynolds, M.B., B.S. Lond.—*British Medical Journal*, 15th August, 1908.

Birth.

CARD.—On July 30th, at Muswell Rise, the wife of Alfred H. Card, M.R.C.S., L.R.C.P. Lond., of a son.

Marriages.

ACKROYD—SMYTHE.—On August 1st, at All Saints' Church, Southport, Harold Ackroyd, M.A., M.B., B.C., youngest son of the late Edward Ackroyd, of 8, Morley Road, Southport, to Mabel Robina Smythe, late Matron of the Research Hospital, Cambridge.

GATER—PERCIVAL.—On the 15th July, at Dunga Gali Church, Murree Hills, Punjab, India, Capt. A. W. Gater, R.A.M.C., third son of John Gater, Black House, West-end, Southampton, to Rosalie, youngest daughter of the late Samuel Percival, and granddaughter of the late General Ricketts, Indian Army.

SMEDLEY—GUBB.—On Wednesday, the 5th August, at St. Pancras Church, by the Rev. H. W. Teesdale, M.A., brother-in-law of the bridegroom, assisted by the Rev. D. Budge, M.A., Ralph Davies Smedley, M.D., second son of the late Isaac Smedley, J.P., County of Pembroke, and of Mrs. Smedley, of 53, Barrowgate Road, Chiswick, to Florence Erin Gubb, M.B., eldest daughter of Alfred S. Gubb, M.D., of Mustapha Superieur, Algiers, and of Aix-les-Bains.

TA BOIS—KEATS.—On the 5th August, at Holy Trinity, Marylebone, N.W., by the Rev. Ernest Mannering, M.A., Leopold Ta Bois, L.D.S., R.C.S. Eng., of "Ben Wyvis," Highgate, to Mabel Maryon, only daughter of the late William Henry Keats, R.N.

WOOD—SPURWAY.—On July 28th, at Tennyson Street Wesleyan Church, Nottingham, by the Rev. J. A. Clapperton, M.A., Frank Thomas Herbert Wood, M.D., B.S., B.Sc., of 4, Harewood Terrace, Darlington, to Clara Maude Lilla, third daughter of Henry Spurway, of Bath.

Death.

DUDFIELD.—On July 30th, at Ealing, Thomas Orme Dudfield, M.D., Medical Officer of Health of the Royal Borough of Kensington, aged 75 years.

Ed.—L. M.

GUY'S HOSPITAL GAZETTE.

VOL. XXII., No. 527.] SEPTEMBER 5, 1908. [SIXPENCE.

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Passim.

GUY'S men on their vacation were no doubt surprised to hear that we had lost three Cups, and these in a manner anything but sportsmanlike. On the night of the 26th ult. some enterprising burglars effected an entry into the Smoking Room and took away with them, as mementoes, the Inter-Hospital Junior Association Cup, the Tennis Trophy presented by Mr. Lane, and the Inter-Hospital Water Polo Challenge Cup. For some reason—maybe they were disturbed, or maybe the size of their sack may have been too greatly increased thereby—they did not interfere with the fifteen other trophies which adorn the walls.

THEIR method of entry into the Club is still a mystery, but the theory held by the detectives who are investigating the robbery is, that they must have entered by the main entrance in St. Thomas' Street, passed along the subway and opened the small door on the spiral steps, and so passed into the scullery. Evidently the miscreants were acquainted with the geography of the Club premises, for they immediately sought and found the keys of the Smoking Room, in the steward's office. They left traces of their presence here, the room being littered with cigarettes and papers. The safe had been tampered with, but had successfully repulsed their efforts at forcing the lock. They then evidently crossed the passage, removed the Cups, and made their exit through the tradesmen's entrance.

UP to the present, no signs of their apprehension, nor any clue to the fate of the trophies, are to hand. The Cups, we believe, were covered by insurance, so that no financial loss will be incurred. It is not too comforting to know that an entrance can so easily be effected, but, no doubt, steps will be taken to remedy this.

THIS was not the only visit that these gentlemen with collecting propensities paid the hospital; for the commissionaire on his return from his holiday had a tale of woe to unfold. The small window in the area near the Medical School Office steps had been forced; the visitors had made strenuous attempts on the cupboard where the microscopes were kept, but a strong six-inch iron bolt had withstood their efforts. After making a tour of inspection of the lockers, they decamped with the net gain of one fancy waistcoat which some ardent anatomist had discarded during the hot weather. For a more dramatic description of the above abortive attempt we recommend our readers to the commissionaire himself!

WE have seldom read a more outspoken address to students than that which appears in the student's number of the *Lancet*. It is written in a strain anything but encouraging either to the student himself or his solicitous parents. The shortcomings of medical education in London are dragged into the light of day.

The overcrowding of the early years of study, which we wrote of in our last number, the exacting demands of examiners, and the much-vexed "concentration" question, are touched upon. Much stress is laid upon the handicap of a holder of the conjoint diploma in not being able to style himself M.D., and the remark that there should be a general final qualifying examination of a standard equivalent to the existing conjoint final, giving the successful candidate the right to the title M.D., seems to us one which points to the ideal solution of the problem.

ON another page will be found a letter from a correspondent asking for reliable details *re* motor cars in medical practice. He is keen to have the observations of medicos who use the automobile in their daily work. It is easy enough to obtain full particulars from the motor experts themselves, but then one is apt—as our correspondent points out—to get an opinion that is not altogether free from bias. The motor car has taken a definite place amongst the accessories of general practice. The ease with which one can set off upon an urgent call, the saving of time, and the absence of any question as to fatiguing the hard-worked and patient gee-gee, are all points which have conduced to make it more and more popular with the busy practitioner. Many old Guy's men, no doubt, have had motor experiences, happy or sorrowful, and we would be pleased if they would put these at the disposition of our correspondent. A good article appeared in the *Lancet* of the 22nd August. This may be useful, not only to "A Prospective Purchaser," but also to others who are in the same position.

THE improvements in the Anatomy Department are nearing completion. The large room on the first floor, to be used for operative surgery, has an area of nearly 1,000 feet, and is 100 feet high; two large lantern lights in the ceiling will ensure good light, whilst an installation of electric light will make the winter classes no longer the "dull" affairs they were formerly. The heating arrangements are excellent—exhaust steam coils—whilst the lavatory accommodation is quite luxurious. The injecting room and entrance lobby to the dissecting room are almost completed. Mr. Saltmarsh informs us that the work will be out of his hands before the end of the month.

A VOLUME of occasional addresses, by Dr. W. Osler, the Regius Professor of Medicine at Oxford, entitled "An Alabama Student and other Biographical Essays," will soon be published by the Oxford University Press. The greater portion of the book deals with aspects of the life of physicians in the United States, and Professor Osler is of opinion that in no age and in no land have the Hippocratic ideals been more fully realised than in some of the lives which he portrays. Chapters are devoted to Sir Thomas Browne, Harvey and his discovery, John Locke as a physician, "Keats the apothecary poet," and Oliver Wendell Holmes.

IT is not generally known that London University is the possessor of a magnificent library, which is at the disposal of its graduates and undergraduates. We have received a pamphlet giving a detailed description of the same. It is situated in the central portion of the building, and contains an excellent collection of works, not only of the classics and matters of political economy, etc., but also many medical works and the theses handed in for many years past. Special facilities are given for teachers of the University to borrow these, whilst any student can obtain a reader's ticket by means of a form which is to be signed by two teachers or a member of the Senate.

DR. W. H. WILLCOX, Lecturer on Public Health, Pathological Chemistry, and Forensic Medicine at St. Mary's Hospital Medical School, has been appointed senior scientific analyst to the Home Office, in succession to the late Sir Thomas Stevenson.

OUR next number is our Annual Students' Number. We would like to remind all those teachers who have not yet returned their proofs to do so. We cordially invite contributions from both present and past men.

Notes on Two Cases from Clinical.

CASE I.

F. H., male, æt. 21, admitted to John ward on August 12th.

Occupation, &c.—Brewer's drayman; takes three pints of beer daily. Has complained of indefinite discomfort and distension after food for last few months. Strong and very muscular man.

At 6 p.m., on day of admission, seized with sudden violent pain in epigastrium. Pain continued till seen in front surgery at 10 p.m. Pulse 80. Complained of the pain, but otherwise seemed fit. Abdomen not distended; very little tenderness present and is localised to a spot four inches below xiphoid cartilage. Board-like rigidity of whole of abdomen and no respiratory movement. Liver dulness normal. Patient vomited a little.

One and a half hours later in the ward.—Pulse still strong and steady. The only change was that the sixth, seventh and eighth spaces on the right side now gave a tympanitic note. A perforating ulcer of duodenum or stomach was diagnosed, and laparotomy performed.

The incision was made through right rectus sheath above umbilicus; gas and turbid fluid escaped on opening peritoneum. Stomach found; no perforation. On tracing along to duodenum there appeared a small clean-cut perforation, a quarter of an inch in diameter, on anterior surface just beyond pylorus. Much force was necessary in retracting costal margin and exposing perforation, but ultimately a purse-string suture was placed around it and the opening closed. It was sewn over once or twice. Fluid mopped out all over abdomen. A small counter-incision was made below umbilicus and drainage tubes inserted.

Treatment.—Quarter grain of morphia given on table. Propped into sitting posture in bed. One pint of saline infused into each axilla; then 10 ♏. of ernutin hypodermically. Continuous rectal infusion. After two pints of saline, 10 ♏. more of ernutin. Patient slept four hours; was allowed water ad lib. by mouth. Was reading newspaper next morning; rectal salines at intervals. Patient drained very freely all day.

Patient went on quite well after this; the bowels opened naturally on third morning. Allowed Plasmon and alkaline milk. Drains removed from upper wound. Fourth day: diet, raw eggs and milk.

[The further progress of this case will be reported later.]

CASE II.

H. W., male, æt. 64. Patient is an old man, much addicted to alcohol. Has well-marked signs of arterio sclerosis and granular kidney. Has complained of slight pain after food for last few months.

At 1 p.m. on the day of admission was found rolling about on pavement, complaining of great pain in the abdomen, which he said had come on quite suddenly.

At 1.30 p.m., in the front surgery, patient still in much pain. Pulse 80. Temperature 95°. Much pain and tenderness and some rigidity in the right flank, especially over liver. Area of normal liver dulness gave a just perceptible resonance. Abdomen not distended. Some movable dulness in right flank. Thickened cord in right inguinal region. No hernia.

5 p.m. Pulse 96. Temperature 95°. Pain increased again. Abdomen generally rigid and tender, worse on right side. Liver area gave a hyper-resonant note. Irreducible hernia in right inguinal canal. Hernia reduced under anæsthetic, but pain worse on regaining consciousness.

7 p.m. Second anæsthetic given. Incision in right linear semilunaris, above umbilicus. On opening peritoneum, gas and turbid fluid escaped. No odour. Stomach examined. No perforation. On tracing along to duodenum, a small clean-cut perforation ⅜ in. in diameter found on anterior surface just beyond pylorus. Closed easily by purse-string suture. As much fluid as possible swabbed out. Small counter-incision below umbilicus. Four large tubes left in. Patient was given strychnine and ernutin. Three-hourly saline into each axilla and per rectum. Never rallied after the operation. Died nine hours later.

H. A. S.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Motoring Experiences.

DEAR MR. EDITOR,—The motor car plays an important part in the lives of so many practitioners nowadays that we can quite imagine in the future a department established as an adjunct to the dissecting-room for the study of its anatomy and physiology, to say nothing of its functional and organic disorders. But without waiting for that, I believe that if you published in your columns the motoring experiences—always valuable and sometimes costly—of old Guy's men, it would be of the greatest service to prospective purchasers.

It was evident at the recent Biennial Dinner that motoring was a common topic of conversation, and there is undoubtedly abundant "clinical" material to draw on. A doctor's requirements are not necessarily those of an ordinary tourist. The frequent stoppages, and in town work the turning of corners and handling in traffic, are three out of many factors which are of importance to us.

My experience is that really independent advice is very difficult to obtain. If you consult a "motor expert," he often has a financial bias in the recesses of his brain. A friend is often wedded to his own pattern of car and ignorant of others.

Collective information would, I believe, be most useful to many besides

A PROSPECTIVE PURCHASER.

The Pirquet and Calmette Reactions.*

THE increasing importance attached to the recognition of tubercular disease in its early stages should ensure a considerable number of readers for this publication, in which Dr. Wolff-Eisner recounts the results of modern methods of investigation. Most of these are the direct descendants of Koch's tuberculin method. This, though still one of the most reliable processes in use, is sometimes attended with some dangers and inconvenience—pains in the limbs and headache. etc. It also requires close observation of the temperature for several days, which we learn from Dr. Wolff-Eisner is not nearly so simple a process in Germany as with us, since German thermometers, though sold as "minute" thermometers, require ten or more minutes for exact measurement. Much more convenient are the more recent local reactions, the Cutaneous Reaction of Pirquet and the Conjunctival Reaction. The latter the author claims to have published four weeks before Calmette, who is generally accredited as the originator. Though familiar with the latter at Guy's, the former reaction is probably unknown to most of us. It consists of a vaccination with tuberculin, generally Koch's old tuberculin, a control inoculation with sterile salt solution being also made. A positive reaction is made manifest in the appearance at the inoculation site of localised redness and infiltration, reaching its maximum in twelve to twenty-four hours, and fading away in a day or so. Subjective symptoms are extremely slight. The technique of the conjunctival method is very simple. The lower eyelid being drawn down and the head held somewhat back, a drop of the solution is instilled on to the conjunctiva, the eyelid and head being subsequently kept in the same position for another half a minute. Wolff-Eisner uses a 1 per cent. solution of Koch's old tuberculin in sterile salt solution. The reaction appears in slight redness going on to mucous exudation, and rarely to chemosis, the conjunctivitis being often follicular in character. Pre-existing conjunctivitis need not preclude its use, and in the normal eye it has never been followed by unfavourable symptoms. Great care must, however, be taken in dealing with any pathological condition of the uvea, iritis, etc., which, if tubercular, are an absolute contra-indication to the ordinary method. A few disastrous results have been recorded in such cases; in these Wolff-Eisner recommends that the investigation should commence with very weak solutions, 1—100,000, followed by instillations of solutions gradually increasing in strength. We find no confirmation of the recent statement made by a contributor to the GAZETTE to the effect that the conjunctival reaction has, from its unreliability, given way in Germany almost entirely to the cutaneous reaction. Our author, in his very numerous cases, uses both, and attributes perhaps a higher diagnostic value to the conjunctival, but a higher prognostic value to the cutaneous reaction. In tuberculosis of the lungs the strongest reactions occur, not in the manifest, but in the unsuspected cases, the percentage of responses decreasing as the disease progresses. Yet absence of response does not indicate the stage of the disease so much as absence of capacity to react, such cases passing rapidly from one stage to another. Miliary tuberculosis, except in children whose reactive capacity lasts long, does not often give a reaction. Of 192 patients treated in hospital for other diseases, one half gave positive cutaneous results, 35 positive conjunctival. Wolff-Eisner's explanation is that the cutaneous reaction indicates also the presence of inactive tuberculous centres, the ophthalmic only that of fairly active mischief, and this is partly borne out by post-mortem results. The reactions are especially useful in children, in whom they immediately indicate tubercular invasion.

We also commend to our readers the discussion of the theory of tuberculin and of the prophylaxis of the disease, in which he quotes a remark of Grancher. "Each country combats tuberculosis in its own way, Germany by means of sanatoria, England with beef-steak and onions. Personally I prefer the English method; it is more pleasant and more efficacious." A survey of other diagnostic methods follows. In sputum, besides the presence of the bacilli and elastic fibres, he regards the presence of a high percentage of lymphocytes as most significant of incipient phthisis. The Röntgen-rays, though inadequate for early diagnosis of pulmonary trouble, are most useful for detecting disease of the bronchial glands. A full bibliography concludes a good treatise, full of original work, which is worthy of a more adequate index.

A. S. M. P.

*The Ophthalmic and Cutaneous Diagnosis of Tuberculosis. By Dr. A. Wolff-Eisner; translated by Bernard T. Robert. (John Bale, Sons & Danielson.) 7s. 6d. net.

Constipation.*

CLINICAL LECTURE BY DR. HERTZ.

GENTLEMEN,—In discussing constipation the first thing to consider is exactly what is to be understood by the term. A person is generally considered to be constipated when his bowels are not opened regularly every day. But there are many perfectly healthy people whose bowels only act on alternate days, and there are some whose bowels are opened much less frequently than that. Dr. Morton tells me that, when he was working in an Edinburgh dispensary, a large number of old women who came to him had their bowels opened only once every four or five weeks, and when he gave them a purgative and it resulted in their bowels acting before the expected time, they came back on the next occasion furious at the result. But for practical purposes I think we may take it that anybody whose bowels are not opened at any rate once in forty-eight hours should be considered to be constipated.

It is, however, important to remember that it is possible to be constipated in spite of having the bowels opened daily. Thus it is necessary to inquire whether the amount excreted every day corresponds with the amount of fæces which the food taken during the previous day should produce. Moreover the passage of very hard and dry fæces, causing painful defæcation, even if this occurs daily, shows that there is undue delay in the alimentary canal resulting in an abnormal amount of fluid being absorbed. It is even possible for a person whose bowels are opened every day to be so extremely constipated, if an insufficient amount of fæces is excreted, that serious results may follow. In a well-known case of Nothnagel's, the patient did not recognise that he was constipated, as his bowels had always been opened every day, but he died from peritonitis following the perforation of a stercoral ulcer, because a small proportion of what should have been excreted was retained each day, so that an enormous quantity accumulated in the colon. It is possible to bring together all classes of cases by regarding constipation as a condition in which none of the residue of a meal taken twelve hours after defæcation is excreted within thirty-six hours. Most people excrete a little of it already in twelve hours, and one can fairly say that an individual who does not excrete any of it either then or twenty-four hours later is constipated. In doubtful cases in which it is thought that a patient may be constipated, although his bowels are opened every day, two or three charcoal lozenges should be given with some food twelve hours after defæcation. If none of the fæces passed during the next thirty-six hours are coloured black, the patient may be considered constipated.

In order that the bowels may act regularly, that is to say, in order to avoid constipation, the passage of the food through the alimentary canal should in the first place be at the normal rate, and secondly, when the fæces have reached the rectum, they should be excreted normally. There are two great classes of constipation: those cases which are due to the slow passage through the alimentary canal, and those which

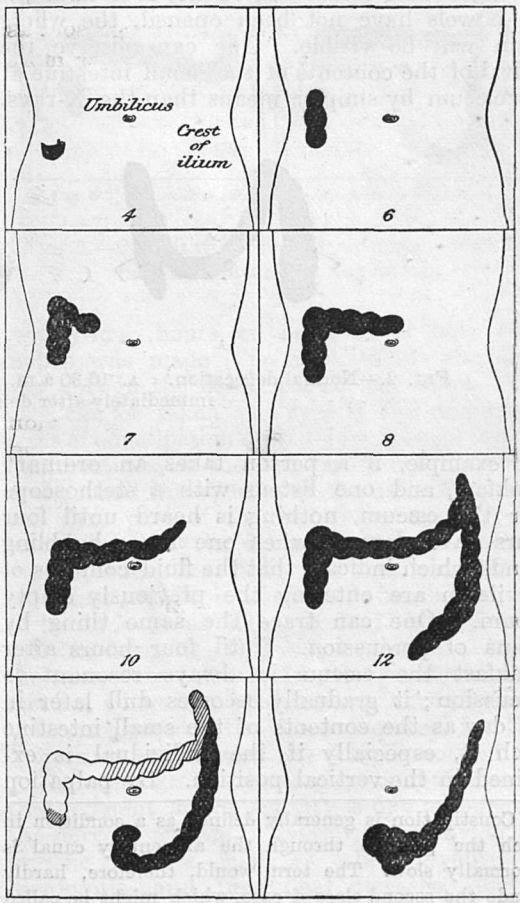

FIG. 1.—Series of colon skiagrams in a normal individual. The numbers represent the hours after a bismuth breakfast was taken.

* Reproduced by the kind permission of the Editor of the *Cinical Journal*.

are due to inability to defæcate completely.* I will briefly go over with you the physiology of these two processes, which must be understood before the causes and the appropriate treatment of constipation can be profitably discussed.

It is possible by means of the X-rays, after having given an individual two ounces of bismuth oxychloride in bread and milk, to trace the food through the alimentary canal. This diagram which I show you indicates the average normal passage of food through the intestines (Fig. 1). Four hours after a meal is taken there is a small shadow seen in the cæcum. Two hours later the shadow reaches the top of the ascending colon. In another hour it will have got half-way across the transverse colon. Ten hours after the meal is taken it will have reached the splenic flexure, and in another couple of hours it will be some distance down the descending colon. In twenty-four hours, if the bowels have not been opened, the whole colon will be visible. One can observe the arrival of the contents of the small intestine at the cæcum by simpler means than the X-rays. For example, if a person takes an ordinary breakfast, and one listens with a stethoscope over the cæcum, nothing is heard until four hours have elapsed, when one hears bubbling sounds which indicate that the fluid contents of the ileum are entering the previously empty cæcum. One can trace the same thing by means of percussion. Until four hours after breakfast the cæcum is always resonant to percussion; it gradually becomes dull later in the day as the contents of the small intestine reach it, especially if the individual is examined in the vertical position. By palpation the changes in amount and consistency of the cæcal contents can also be recognised.

We now come to the question of defæcation. The desire to evacuate occurs as soon as a certain amount of fæces has collected in the rectum, which is normally almost empty. The act of defæcation begins with the voluntary contraction of the diaphragm and the abdominal muscles. By these means the intra-abdominal pressure is greatly increased, and the fæces in the sigmoid flexure move towards the point of least resistance, that is to say, the anus. The rectum thus becomes distended, and the normally empty anal canal now contains some fæces. These two factors give rise to the reflex act of defæcation, which consists in the peristaltic contraction of the whole of the colon and the cæcum, and not only of the descending colon, as formerly taught. The internal and external sphincters of the anus are simultaneously relaxed. There is thus a movement of the entire contents of the large intestine towards the anus, which is most marked in the distal part, so that normally all the colon below the splenic flexure empties itself completely. The process is seen in Fig. 2, which also shows the effect of the descent of the diaphragm on the shape and position of the colon. The voluntary contractions of the diaphragm and abdominal muscles are generally maintained throughout the act of defæcation, so as to increase the effect of the involuntary peristalsis of the colon.

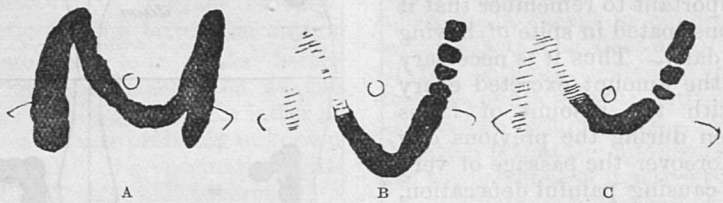

FIG. 2.—Normal defæcation. A. 10.30 a.m., immediately before defæcation. B. 10.35 a.m., immediately after defæcation. C. 12.20 p.m.

We now come to the classification of cases of constipation. The list which I have written up (see the end of this paper) looks a long one, but it is not generally difficult to decide to which class a given case belongs, because one can recognise the cause in the majority of instances simply from the history and by a thorough general examination of the patient. The first of the two groups (I), constipation proper, contains those cases which are due to the slow passage

* Constipation is generally defined as a condition in which the passage through the alimentary canal is abnormally slow. The term would, therefore, hardly include the second class of case, which might be called "*dyschezia*" (δύς, difficult; χέζω, I go to stool), a word first introduced by Robert Barnes to denote painful defæcation.

through the intestines, and the second, "dyschezia" (II), those in which defæcation is abnormal. One can separate these two classes from each other by rectal examination, which should always be made in a severe case of constipation that is not cured by ordinary simple means. The descending colon, sigmoid flexure and rectum should be emptied by defæcation. So if defæcation is normal and there is merely a slow passage through the intestines, the rectum will be found to be almost empty. If the passage through the alimentary canal is normal, but the act of defæcation is inefficient, examination will show that the rectum is distended with fæces, and perhaps even that the anal canal contains fæces.

The first class can be further subdivided into (A) cases due to deficient motor activity, and (B) those due to obstruction. Here again there is a rough general way of distinguishing between these two groups. Where the constipation is due to deficient motor activity there will be no colic, peristalsis being less powerful than it should be. But if there is something obstructing the passage of the material down the intestine, the part of the intestine above the obstruction will be abnormally active, as can be seen by means of the X-rays, the shadow of a bismuth meal passing down abnormally rapidly as far as the obstruction. There is thus overactivity of the intestinal muscles, which are trying to overcome the obstruction, and this may cause colic. There is also likely to be a certain amount of flatulence in these cases, because of the retention of gas behind the obstruction.

Constipation due to deficient motor activity may in the first place (1) be due to abnormal intestinal musculature. This is probably the cause of the constitutional constipation, occurring in people whose bowels from birth have acted sluggishly. One finds whole families suffering from the same condition. Deficient activity of the intestinal muscle may be due to anæmia, particularly chlorosis. Almost every chlorotic girl is constipated, and the constipation is due to the same sort of change which gives rise to her cardiac troubles. The heart is often dilated owing to the poor blood which feeds its muscle. Similarly there is an insufficient supply of blood to the intestinal musculature, so that it becomes inefficient. In the cachexia of tuberculosis and of cancer one meets with the same thing. A large majority of old people are constipated, owing probably to the gradually increasing weakness of the intestinal muscle, in which definite atrophic changes have been demonstrated. As an example of this class of constipation I show you these tracings from a case of chlorosis. A bismuth breakfast was given at 9.15 a.m. on August 8th. The cæcum was reached in four and a half hours (Fig. 3, *a*), and the middle of the transverse colon two hours later (Fig. 3, *b*), so that up to this point the rate of progress was normal, but in the next

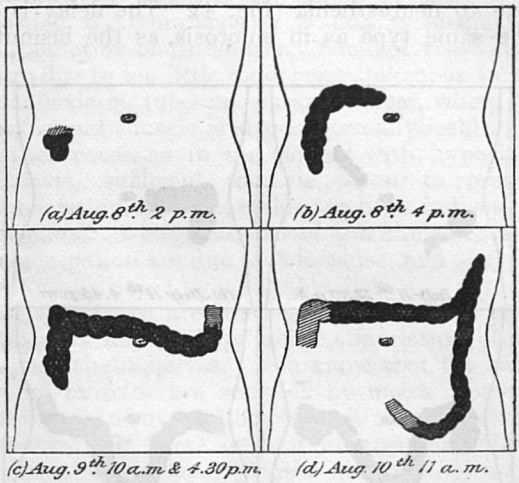

Fig. 3.—Constipation due to chlorosis. Bismuth meal at 9.15 a.m. on August 8th.

twenty-four hours an advance of only three inches was made (Fig. 3, *c*). Thus the delay was only in the distal part of the colon. This case can be taken as a type of the majority of cases of constipation due to slow passage through the intestines, as there is hardly ever any delay in the small intestine, or in the ascending colon and first part of the transverse colon. The reason is that the contents in these parts of the intestine are fluid, so that even if the intestinal muscle is abnormally weak, the work to be done is so light that it has no difficulty in doing it. It is only in the distal half of the transverse colon and in the parts nearer the rectum, where the contents are normally solid, and consequently the force required for their propulsion greater that the delay is noticed.

The next group of cases (2) is that in which the deficient motor activity is due to defects in the nervous system. These we can divide into organic diseases, such as tabes, myelitis and meningitis, and functional diseases, such as neurasthenia, hypochondriasis and melancholia. One of the most frequent causes of constipation is neurasthenia, the deficient intestinal activity

being due to depression of the nervous system. The normal stimuli to intestinal peristalsis are, firstly, the mechanical irritation produced by the undigested residue of the food, and secondly, the chemical stimulus produced by such substances as organic acids and sugar. When the nervous system is depressed, the residue of the food does not produce sufficient stimulation of peristalsis. Here is an example of constipation due to neurasthenia (Fig. 4). The delay is of the same type as in chlorosis, as the bismuth reached the cæcum and the transverse colon in the normal time, the passage through the transverse and descending colon being abnormally slow. When by suitable treatment the neurasthenia is cured, the constipation also disappears. Here are tracings (Fig. 5) from an interesting case, that of a medical man with hypochondriasis. He was forty years old, and had spent the last twenty years of his life thinking about his inside, examining his excreta, and palpating his abdomen. He was convinced that after all this time he knew the exact condition of every part of his intestine. He said that his transverse colon was in his pelvis, as he could feel it there himself; the beginning of his descending colon was, he believed, normal, but it ended in a sort of funnel, the rest of the descending colon being exceedingly small, with a lumen no broader than a lead pencil. He explained the fact that he excreted normal fæces by a comparison with the moulds that earthworms throw up: thus a thin strand of fæces was squeezed through the stricture, and then coiled round in the normally-sized rectum; as soon as a moderately large mass was formed he excreted it. In consequence of this extraordinary condition, which he thought he had, he dieted himself in such a way that the food should leave only a minimal residue; consequently there was very little to stimulate peristalsis. He wanted Mr. Lane to remove his colon. Mr. Lane, however, thought that the case would probably turn out

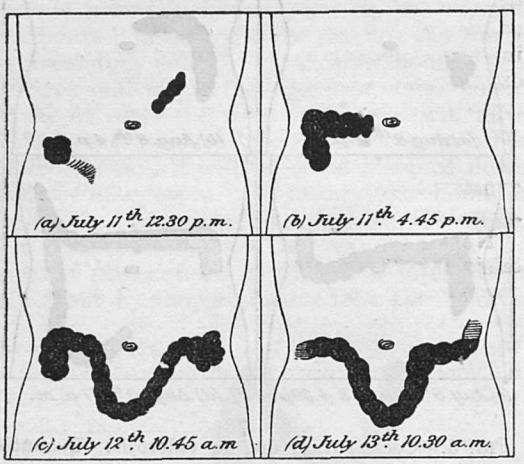

FIG. 4.—Constipation due to neurasthenia. Bismuth breakfast at 8 a.m. on July 11th.

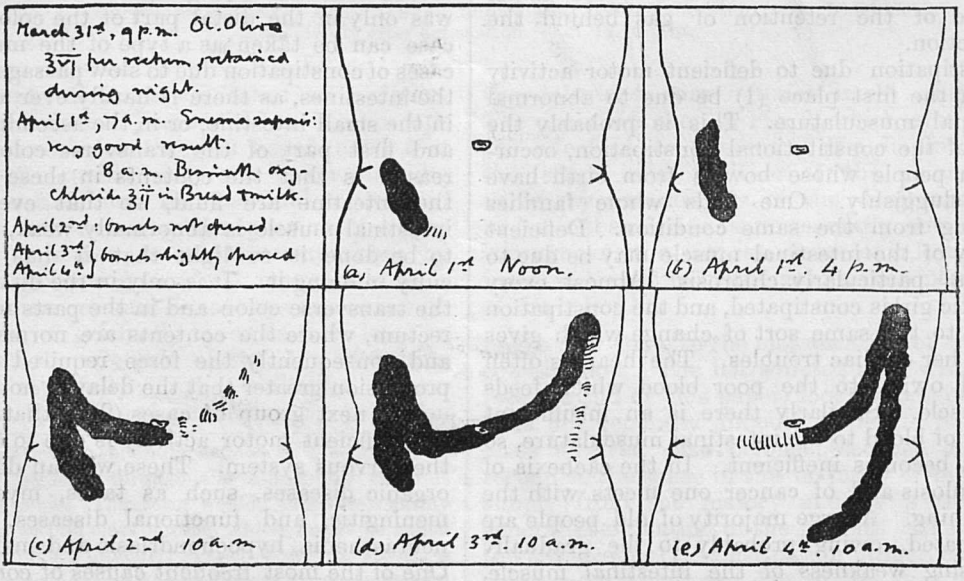

FIG. 5.—Constipation associated with hypochondriasis.

to be unsuitable for colectomy, so he asked me to examine him with the X-rays. It was found that bismuth reached the cæcum at about the normal time, but that throughout the colon there was a very definite slowing (Fig. 5). But the lumen of the descending colon was perfectly normal, and the only abnormality was that four days instead of one and a half days were required for the series of tracings shown to be taken. I was able to convince the patient that the funnel arrangement which he imagined he had did not exist, and that if he took normal food he would get rid of his constipation. This he did, aperients being also ordered for a time, so as to produce the extra stimulus necessary for his intestine, which had been inactive for so long a period. The result was that his bowels were regular during the short period he remained under observation. The next series of tracings (Fig. 6) is from a case of tabes. Here, again,

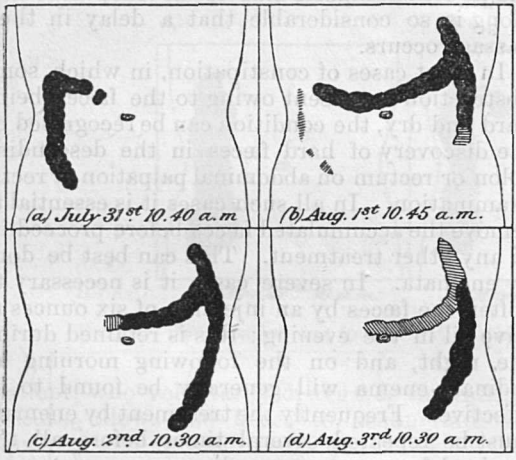

FIG. 6.—Constipation due to tabes dorsalis. Bismuth breakfast at 6.30 a.m. on July 31st.

the delay is only in the peripheral part of the colon, the progress of the food as far as the middle of the transverse colon being normal. In tabes there is often a deficient nervous supply to the bladder, so that difficulty in micturition occurs. The frequent occurrence of constipation is similarly due to deficient nervous supply to the bowel. The constipation can be easily cured by ordinary purgatives (Fig. 7). By this means it is possible to increase the stimulus to the intestinal muscle, the local nervous system of which is still sufficiently active to be able to respond to a strong stimulus.

Now we come to the group of cases (3) in which the constipation is due to insufficient stimulation of peristalsis. Some of these cases are due to too little food being taken, as in the cachexia of tuberculosis and cancer, where the intestinal muscle is also abnormally feeble. In other cases, as in the patient with hypochondriasis, sufficient food is taken to prevent emaciation, but it contains too little indigestible residue. A large number of the milder cases of constipation are due to this cause, and they are all easily cured by a suitable diet.

Next there are the cases (4) in which peristalsis is inhibited by reflex stimulation of the sympathetic nerves. You know that the intestinal muscles are supplied by motor fibres in the vagi and by inibitory fibres in the sympathetic nerves. If there is pain in any part of the body, but especially in the abdomen, owing to disease of the stomach, appendix, uterus or ovary, the pain produces reflex inhibition of the intestinal movements, most probably through the sympathetic nerves. The evidence for this is that such cases of constipation can be cured or relieved by means of opium or beladonna; that is to say, instead of giving a purgative to increase the peristalsis, one gives a sedative to diminish the inhibitory action of the sympathetic nerves. Reflex inhibition is also the cause of the complete cessation of gastro-intestinal activity, which follows the perforation of an abdominal viscus, even before the stage of general peritonitis, in which inflammation of the intestinal muscles themselves makes the constipation still more intractable. Then there is the irritative stage of lead poisoning. In lead

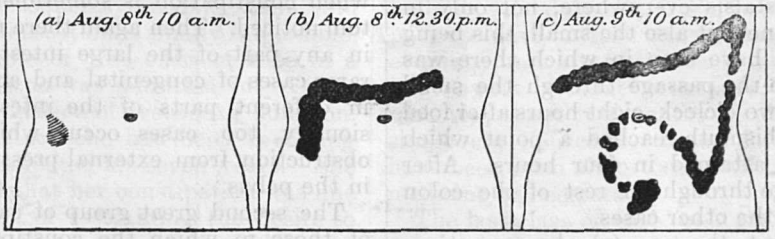

FIG. 7.—Same case as in Fig. 6, under treatment with purgatives. Bismuth breakfast at 6.30 a.m. on August 8th.

poisoning two different conditions may give rise to constipation. Firstly, the sympathetic nerves may be irritated by the poison. When that is the case movement along the alimentary canal is unduly slow. If at a later stage the sympathetic nerve becomes partially paralysed (5) instead of being stimulated, the motor impulses have free play, uncontrolled by the sympathetic inhibitory action, so that the normal peristalsis, in which contraction behind the fæces and relaxation in front of them causes a steady movement forward of the contents of the canal, is replaced by quite irregular contractions, giving rise to colic in addition to constipation. That such a second stage of lead constipation exists is proved by the fact that a number of cases of lead colic have been operated upon with the idea that they were cases of peritonitis, and coils of intestine have then been seen to be contracted tightly into white cords no thicker than a lead pencil. Fig 8

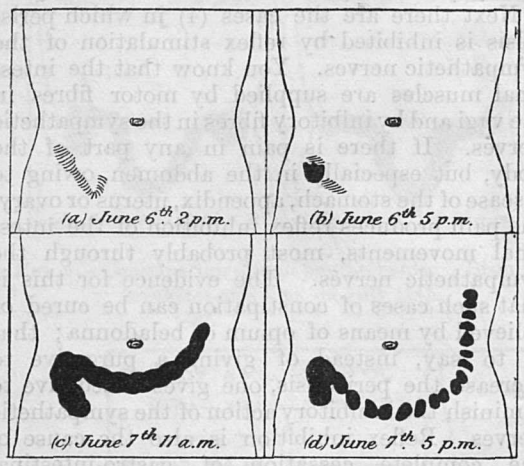

Fig 8.—Constipation due to lead poisoning. Bismuth breakfast at 6 a.m. on June 6th.

is taken from a patient suffering from lead poisoning with constipation without colic. Hence probably there was irritation, and not paralysis of the sympathetic nerve; the irritation of the sympathetic nerve produced a diminution in the activity of peristalsis everywhere, not only in the large intestine but also the small, this being the only case I have seen in which there was definite delay in the passage through the small intestine. At two o'clock, eight hours after food was taken, the bismuth reached a point which it should have attained in four hours. After that, the passage through the rest of the colon was slow, as in the other cases.

We now come to the cases (B) where constipation is caused by obstruction. The first group (1) of such cases consists of those in which the obstruction is due to dry and hard fæces. If in any case of constipation due to one of the causes already considered, or to inability to defæcate, a mass of fæces collects, particularly in the descending colon, sigmoid flexure or rectum, it may become so hard and dry that the intestinal muscle is unable to push it forward, so that more or less complete obstruction results.

Another cause of obstruction by dry hard fæces is the drinking of too little water owing to the absence of thirst, or in women owing to their desire to micturate as rarely as possible. In other cases water may be replaced to an abnormal extent by alcohol. The severe constipation of diabetes is mainly due to excess of water being excreted in the urine, and that sometimes following hard exercise is due to loss of water by excessive sweating. If the contents of the colon are abnormally hard and dry, the work which the intestinal muscle has to do to push them along is so considerable that a delay in their passage occurs.

In most cases of constipation, in which some obstruction is present owing to the fæces being hard and dry, the condition can be recognised by the discovery of hard fæces in the descending colon or rectum on abdominal palpation or rectal examination. In all such cases it is essential to remove the accumulated fæces before proceeding to any other treatment. This can best be done by enemata. In severe cases it is necessary to soften the fæces by an injection of six ounces of olive oil in the evening; this is retained during the night, and on the following morning an ordinary enema will generally be found to be effective. Frequently the treatment by enemata must be repeated several times before all the retained fæces are removed.

The second group (2) of obstruction cases consists of those in which there is organic obstruction due to diminished lumen of the alimentary canal. It is this condition which one always has to think of in cases of constipation coming on suddenly in people of middle age. It may be due to a growth of the pylorus, when constipation is sometimes the first symptom noticed. Then again there may be a growth in any part of the large intestine. There are rarer cases of congenital and acquired stricture in different parts of the intestine, and occasionally, too, cases occur which are due to obstruction from external pressure, particularly in the pelvis.

The second great group of cases (II) consists of those in which the constipation is due to inability to defæcate efficiently—dyschezia. The

majority of cases of very severe constipation, such as those in which the bowels may not be open for several weeks, are examples of this condition, so that ileo-sigmoidostomy, with or without colectomy, which has recently been proposed as treatment for constipation, would clearly be useless, as it would remove a normal colon without curing the inability to defæcate. The inability is due to one of three causes: (A) Loss of the defæcation reflex, (B) atonic dilatation of the sigmoid flexure and rectum, or (C) atony of the voluntary muscles employed in the act of defæcation. The first two of these frequently go together, and they originate in the voluntary disregard of the call to defæcation. This is particulary frequent in girls and women, in whom it is due to false modesty or to laziness. It is sometimes due in both sexes to fear of defæcation on account of the pain incurred in the act, owing to the presence of piles, anal fissure, or other disease in the pelvis. In time

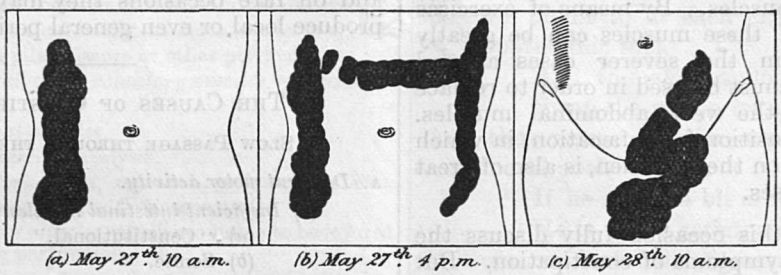

FIG. 9. – Constipation due to inability to defæcate. Bismuth breakfast at 6 a.m. on May 27th.

a patient, who voluntarily disregards the call to defæcate, allows the fæces to accumulate so frequently and in such large quantities in the rectum and sigmoid flexure that the defæcation reflex becomes impaired. The sensitiveness of the mucous membrane is so blunted that these patients frequently tell you that they have no desire to defæcate, even though you have found by digital examination that the rectum is distended with fæces. The accumulation of fæces distends the rectum and the sigmoid flexure, which consequently become atonic and paretic, so that defæcation is finally impossible. Here is an example of this class of case in a girl æt. 17 years, who was admitted into Guy's for complete constipation of five weeks' duration. Previous to this attack she had been becoming steadily more constipated for seven years. She herself recognised that her constipation was due to her former habit of restraining the desire to defæcate in order to get to school and later on to her work in time, in spite of getting up late. The tracings (Fig. 9) show that the passage through the small intestine and colon was abnormally rapid, but that the fæces accumulated in her enormously dilated sigmoid flexure and rectum. In spite of this she felt no desire to defæcate and she was unable to do so when she made the attempt. By means of enemata, which are the only effective treatment for such cases, the rectum and sigmoid flexure were emptied. For a year now she has used enemata on alternate evenings and has kept well, except for occasional relapses due to neglecting to use the enemata; on these occasions the skilful administration of an enema by a nurse has always had the desired effect. In some cases of this sort the continual administration of enemata, by keeping the rectum and sigmoid flexure empty, allows their musculature to regain its tone and the sensibility of the mucous membrane to return, so that voluntary defæcation becomes once more possible. Thus a woman, æt. 54 years, had been constipated for thirty-three years, and had been unable to defæcate without enemata for twelve years. She had been taking large quantities of drugs and had used enemata once or twice a week, when it was supposed that the purgatives had caused a sufficient amount of fæces to collect in her rectum for the enema to work upon. The X-rays showed, however, that there was very little delay in the colon; the rectum was found to be constantly full, so that the constipation was clearly due to inability to defæcate. For six months the patient gave herself an enema on alternate evenings and attempted each morning to open her bowels without assistance. At last one morning, about two months ago, she found that she could defæcate. Since then her bowels have been open almost daily without the aid of medicine or enemata.

The last class of case (C) is that in which the dyschezia is due to weakness of the voluntary muscles which normally take part in the act.

In some women who have borne many children this may be partly due to injury of the muscles of the pelvic floor. But the most important group of cases is that in which the abdominal muscles are weak. This is frequently due to the stretching produced by repeated pregnancies or by the accumulation of fat or fluid within the abdomen. In such cases there is more or less well-marked visceroptosis, and many authorities have thought that the constipation was due to the enteroptosis, the passage of fæces being blocked by kinks at the hepatic and splenic flexures of the colon. But observations with the X-rays have shown that these flexures are as sharp in the majority of normal individuals in the erect posture as in the severest cases of enteroptosis. Moreover, I have not yet seen in cases of constipation associated with visceroptosis any delay at the flexures, and in fact the fæces generally reach the sigmoid flexure in normal time. The constipation is due to inefficient defæcation owing to the weakness of the abdominal muscles. By means of exercises the condition of these muscles can be greatly improved, but in the severer cases a good abdominal belt must be used in order to replace to some extent the weak abdominal muscles. The crouching position for defæcation, in which the thighs press on the abdomen, is also of great value in such cases.

I cannot on this occasion fully discuss the question of the symptoms of constipation. But I wish to warn you against becoming fascinated by the theory of auto-intoxication, which is so popular at the present day, and which ascribes most of the ills of mankind to "copræmia," or poisoning by substances absorbed from fæces retained too long in the alimentary canal. Personally I doubt whether, so long as no stercoral ulcers have formed, any of the symptoms associated with constipation are due to this cause. Many are simply additional symptoms of the condition, such as neurasthenia or chlorosis, which has given rise to the constipation. This is also the case in visceroptosis, in which a suitable abdominal belt, by preventing the drag of the viscera on the attachments of the mesentery, relieves the pain and other disturbances at once, even before the constipation has disappeared. In mild cases of constipation some of the symptoms, such as headache, a feeling of slackness and slight abdominal discomfort, are due probably to a reflex from the distended rectum, as it is a matter of common experience that they are relieved instantaneously when the bowels are well opened, although this would be impossible were they due to auto-intoxication.

Certain neuralgic pains are perhaps caused by pressure on nerves, and the frequent association of hæmorrhoids with constipation is often due to local interference with the circulation by the pressure of hard fæces accumulated in the rectum. When there is any considerable degree of obstruction from impacted fæces, flatulence may be troublesome and colicky pain may occur. Defæcation is generally more or less painful, and the straining required may give rise to hernia, prolapse of the rectum or uterus, syncope or cerebral hemorrhage in those disposed by pre-existing abnormalities to these conditions.

Finally a catarrh of the rectum with spurious diarrhœa and tenesmus may be brought on by the irritation of a fæcal accumulation, and impaction of fæces may occasionally produce stercoral ulcers in the rectum or sigmoid flexure. These ulcers may be associated with pericolitis, and on rare occasions they may perforate and produce local or even general peritonitis.

THE CAUSES OF CONSTIPATION.

(I) SLOW PASSAGE THROUGH THE INTESTINE.

A. *Deficient motor activity.*

(1) *Inefficient intestinal muscles.*

(*a*) "Constitutional."

(*b*) Senile.

(*c*) Anæmia, especially chlorosis.

(*d*) Cachexia of tuberculosis and cancer.

(2) *Depression of central and peripheral nervous system, resulting in diminution in the response to stimuli which normally produce peristalsis.*

(*a*) *Functional.*
Neurasthenia, hypochondriasis, melancholia.

(*b*) *Organic.*
Tabes, myelitis, meningitis, etc.

(3) *Insufficient stimulation of peristalsis.*

(*a*) Too little food.

(*b*) Food containing too little indigestible residue or chemical stimulants.

(4) *Stimulation of sympathetic nerves inhibiting peristalsis.*

(*a*) Reflex from painful organ.

(*b*) Irritative stage of lead poisoning.

(*c*) Perforation of abdominal viscus.

(5) *Paralysis of sympathetic inhibitory nerves permitting irregular peristalsis.*
Paralytic stage of lead poisoning.

B. *Obstruction.*

(1) *Dry, hard fæces.*

(*a*) Resulting from fæcal retention, brought about by any of the other causes of constipation.

(*b*) Too little water.

(i) No thirst.

(ii) In women to diminished frequency of micturition.

(iii) Replaced by alcohol.

(*c*) Excessive secretion of urine—diabetes.

(*d*) Excessive secretion of sweat—after hard exercise and in hot weather.

(2) *Diminished lumen of alimentary canal.*

(*a*) Congenital or acquired stricture, including growth: œsophagus, pylorus, intestine, anus.

(*b*) Pressure from outside.

(*c*) ? Kink.

(II) INABILITY TO DEFÆCATE (DYSCHEZIA).

A. *Loss of defæcation reflex.*

B. *Atonic dilated rectum and sigmoid flexure.*

A and B generally together, due to habitual disregard of call to defæcation, owing to sloth, modesty or fear of pain from piles, fissure or other pelvic disease.

C. *Atony or paralysis of voluntary muscles concerned in defæcation.*

(1) *Abdominal muscles.*

(a) Organic paralysis.

(*b*) Weak from repeated pregnancies, etc., associated with visceroptosis.

(2) *Pelvic floor muscles*, which are liable to be injured during parturition.

(3) *Diaphragm.*

August 3rd, 1908.

In Lighter Vein.

TWO THEORIES AND A REMEDY.

You have heard, if you should suffer from an uncorrected eye,
That your general health is not a thing on which you can rely,
And there's loss of vim and verve
If your cornea should curve
More acutely in a vertical than horizontal lie;
And that indigestion drear,
Epilepsy and chorea,
Will be claiming you a victim in the saddened by-and-by,
And you're likely to endure
Nervous lesions most obscure,
All attendant on the danger of this uncorrected eye.

Or, to take another theory, you have heard without a doubt
That the gentleman who murders or who burgles round about
Cannot help it in the least,
He is forced to be a beast
By a kind of morbid cerebrum—a madness that will out;
And that lesions quite obscure
Every day impel and lure
Him to pick a lock, or wallow in a plethora of stout,
And he isn't really bad,
Only just a little mad,
For a disaffected neurone puts his better self to rout.

Now to take the two together—I am confident that you'll
Say we ought to fit each criminal with some ophthalmic tool,
And, to make a syllogism,
Swap the prison for the prism,
And thus rescue him for ever from his murky moral pool.
If he seems a bit erratic
He is really astigmatic,
With his conduct and astigmatism both "against the rule!"
Thus of course it's very clear
With a cylinder and sphere
We shall rectify the villain and evangelise the fool.

If you act on this idea (the necessity is plain),
Just consider the advantages that follow in its train—
Each abolished judge's screw
Will augment the revenue,
And the pulling down of gaols be a pecuniary gain
Of such generous dimensions
There'll be heaps for Old Age Pensions,
Which would set the anxious Asquith in an optimistic vein;
Also, when the Statute passes
And all thieves are cured by glasses,
'Twill be safe to keep some silver in the Smoking-room again.

S. S.

Notes of a Roving Guy's Man.*

VII.

SOME years ago, when I went to Breslau to see Mikulicz operate, I met a Russian doctor who had come to the then Mecca of surgery to inspect the new theatre. The operating room had been built only a couple of years, and was said to be the finest in Europe—even to-day, when the magnificent theatres at the Virchow, at the new Greifswald clinic, and at Leipzig, take the palm, Mikulicz's old theatre, with its quaint motto over the door, must still be reckoned a fine building. It impressed me then, but my Russian friend was by no means so struck with it. "We have as fine at St. Petersburg," he remarked, "and at Odessa there is a nice theatre too." At the time I put down the remark as pardonable exaggeration. We all allow our patriotism to make us forget that we are gentlemen, notwithstanding Burke's warning, and the desire to deprecate what is foreign and to extol what is native is a purely natural one. That it leads to exaggeration is equally natural. The story of the American who, when told that in Liverpool they built jerry-houses so quickly that the roof was on before the foundations were firm, remarked, "That's nothing. In Missouri I saw them putting up the foundations in the morning, and when I passed the place in the evening they were turning out the tenants who had not paid their back rent," rests doubtless on fact. Certainly one is told marvellous things about the rapidity and dexterity of American surgeons! Knowing this tendency to exaggeration I paid little heed to what I was told about Russian hospitals. Since then I have heard exactly opposite accounts. In England I was told—by those who had never been to Russia—"It's an absurd country so far as hospitals are concerned." In Germany, when one mentioned Russia, there was a shrug of the shoulders and a contemptuous smile. After all, Russian students come to Germany to study medicine, just as English doctors to study orthopædics. At Berlin I had the pleasure of meeting many Russian colleagues, and in discussing things with them I was astonished to find that several of them knew a great deal about hospitals and hospital construction, and were able adequately to criticise and comment upon German institutions. Putting the case frankly to them, one day, I was told that Russia possessed excellent hospitals of its own, "Come and pay us a visit," I was invited, "and you will find us very far from being medieval." When I received from Professor Kuttner, a note about what he calls "the magnificent Helena Pawlovna Hospital" at St. Petersburg (which from all accounts is the finest post-graduate institution in the world), I thought it worth while to travel Russiawards.

I do not presume to give more than what are passing impressions here, in the hope that they may be of some interest to GAZETTE readers. It would be the veriest impudence on the part of one who is unfamiliar with the language and customs of a country to presume to give anything like a description of its medical life and manners after a short visit, which allowed only a few institutions to be visited and a cursory comparison to be drawn. All that one can do is to jot down a few notes, apologising for any unwarranted inference that may be drawn with the remark that one tried to view things sympathetically, and to bear in mind that comparisons, to be just, must take into consideration many aspects, and make due allowance for differences of race and custom.

And the first impression one gets on entering Russia on the Cracow-Moscow route is that the country does not much differ from eastern Germany. Everywhere there are stretches of cultivated land, miles and miles of waving corn fields and garden crops, sheltered little hamlets along the line, with here and there a more or less important village. First comes the Polish stretch, and Breslau itself may almost be taken as a part of it. An old town with quaint bye-streets and alley-ways, a fine cathedral, and fine clinical institutions—such is Breslau. Here at out-patients one recognises for the first time how much value one instinctively attaches to the history. When one cannot make head or tail out of what the patient says, the diagnosis is not always so easy, and two cases especially showed me the fatality of making a careless examination, and allowing an initial presumption to weigh in diagnosing. One was a woman of about 24 with an ulcer, hard and somewhat indurated, on the right breast. I felt a few glands in the axilla, and jumped to the conclusion that the case was one of carcinoma. In reality it was a breaking-down gumma, a condition which a closer and more careful examination would have made clear to me. The other was a small boy with numerous glands in the neck, which again one hastily took to be tuberculous. "Oh no," said the professor, "we shaved his head and got rid of his pediculi: the glands are all going down." In both cases the history would have been of material value, though in both, too, greater care and attention to the obvious would have prevented the mistake. Most of the out-patients speak Polish, and do not (or affect not to) understand German. At the orthopædic department one sees many excellent cases, about which I hope to give some particulars later. As I had already on a former occasion visited the surgical side, I did not this time linger there or at Cracow. Cracow itself is equally old, and equally interesting. It is the old capital of Poland, now the seat of an Austrian governor, and incorporated with Austrian Poland. All around are reminders of the old struggle. They show you the spot where the insurgent army made its last stand, on the night before abandoning the city, and behind the town lies the *Kopiec Kosciuski*, a reminder of the great patriot who gave his life for Poland. Wandering round the city one can reconstruct, in imagination, the pathetic picture "Finis Polonia," which is so well known. There stands the Florian tower, and yonder is the Dominican church where the bodies lay. It brings

* Series I., II., III., IV., V. and VI. of Notes appeared in GAZETTE of April 4th, May 2nd, May 16th, June 13th, August 8th and August 22nd.

to mind Peschiera and Arthur Clough's lines, with their fine ending,

'Tis better to have fought and lost,
Than never to have fought at all.

And if one wanted another reminder of the tragic story, there is the daily café talk about the doings of "Young Poland." The Polish question is not dead; it is very much alive, and the national hymn of the Poles is, "We are not finished yet." To those who care little for such things, there are plenty of other interesting sights. The churches are magnificent. That of St. Mary possesses one of the finest high altars, with a beautifully carved choir screen and excellent stained glass windows. For the medical student there are the clinics—old, indeed, but very rich in clinical material, particularly in deformities, and in what one calls (whether justly or not is a matter for discussion) signs of racial deterioration—flat feet, hare lips, clavicular atrophy, and so on. At the surgical clinic, Professor Chlumsky, well known for his work on intestinal surgery, operates daily. Cracow is not a university town, and there are no lectures, but the clinics are visited by many Russian students, and graduate courses are given from time to time.

Even more interesting is Warsaw, with its fine streets and still finer palaces. A city of great names, almost every one of which has figured brilliantly, if sadly, in Polish history. The finest palace is now an infantry barracks, and the city possesses the largest garrison of any town of its size in Europe. This is Russia, and Russian is the official language, but Polish is spoken everywhere. Street life in Warsaw is Parisian in its variety and interest, and in many respects the town is a gay one. There is only one drawback to the full enjoyment of its pleasures, apart from the language, and that is the fact that, like Moscow, it is an expensive place for a stranger. One has to bargain—bargain with one's cab driver, with the hotel waiter, with the shopkeeper, with the railway porters. It is said that this system of bargaining prevails even in official circles, and that the man who sells postage stamps attempts to make a small and wholly illegitimate profit on the sale. Personally I cannot vouch for the truth of this statement. One of the fond illusions which a trip to Russia dispels is the hope that one might have to fight, if only verbally, for the maintenance of one's independence of thought and action. To the foreigner, duly armed with his passport and with the resources of his embassy in mind to help him out of a possible difficulty, the anticipation of a little tiff with Russian officialdom is wholly pleasurable. In my case, at least, no opportunity for such a little encounter arose. The officials were everywhere courteous and kind: the "protectors of the people" in the street, fearsome in their military uniforms and panoplies of war, turned out to be mild and agreeable fellows, who listened with great patience, tempered, perhaps, with some pity at a foreigner's ignorance, to one's appeal for guidance. I was told that I should have a great deal of unpleasantness, especially in public places, and was warned on no account to omit taking off my hat when entering the post-office to buy stamps. For in all public buildings hang the portraits of the "Little Father," and to remain covered in his presence is presumptive proof of one's Nihilistic tendencies, which renders one liable to summary execution. Like so many things that are said about Russia, this is wholly imaginative. Anyone who goes to Warsaw in the hope of indulging his fancy for the morbid by witnessing summary street executions, or the sabreing of innocent folk on the pavement, will be greatly disappointed. Even at the frontier, where the incoming stranger has to put up with some inconveniences (notably in regard to the passing of his books by the custom officials), a frank declaration and a courteous demeanour usually gets one through without the least trouble. Any carriage literature one has with one is scrutinised carefully. At the Russian railway stations (which are, on the whole, very good, especially as far as the refreshment departments are concerned) there are bookstalls, but they do not contain much variety, and the foreign press is almost entirely excluded from the stock exposed for sale. A few French and German novels one can buy, and I invested in a small pile of Verne's and re-read the exhilarating histories of Dr. Fergusson, the Gun Club, and Hector; the collection of Russian books looks attractive enough, but is not of much use to one who does not know the language.

Moscow itself, which is reached after a long but by no means dreary railway journey, is really a fine city, and the picture it presents when the setting sun irradiates the many domes and pinnacles of the old citadel, the Kremlin, and casts a glow over the houses and surrounding slopes, is remarkably attractive. Like Warsaw, it is an expensive city, when one cannot go to the smaller caravanserais, where Russian only is spoken. The large hotels are up to date and luxurious, and charge accordingly, and at the end of his stay the visitor finds that he has to pay for an unwelcome lot of extras. The city itself demands a month, at least, for its full inspection, and as my time was exceedingly limited, I came away without having seen a fourth of the sights. Another inconvenience is the fact that many places are only open on certain days, while for others a special permit must be obtained. Thus the treasury at the Kremlin and the coronation hall, with the church itself, can only be viewed with a special permit. Much more interesting than any regular sights is the contemplation of street life in Moscow. Sitting at a café one can for hours interest oneself in what passes around. On the pavement and in the street stride lines upon lines of people, belonging to all nationalities and garbed in all varieties of costume, from the Thibetan with his huge hat to the Kroat boys with only a shirt and short breeches (both very much torn). All tongues are spoken; the street is a veritable bazaar for variety and interest, and every five minutes something out of the ordinary comes along. One can sit there for hours—the Moscow man, in fact, does—and look on, or listen to the music, for every café has its own band. The music is usually very varied, though English compositions are few on the long repertory, a copy of which lies on every table. Thus at one restaurant, where this list contains no less than 815

different compositions, the only English ones were a few of German, Jones and Coleridge. The Russian appears to like his music classical, and the bands are usually fine, but it is somewhat undignified to eat one's blueberry ice to the strains of Leonore 3, or to sip flavoured vodka to the accompaniment of the overture from Eugene Onegin. The theatres are large and fine, the royal opera and the imperial ballet house being especially worth a visit. At the opera Russian pieces are usually played, including the fine operas, "Pique Dame" and "For the Tsar," neither of which, I believe, has yet been staged at Covent Garden, though the first has often been promised. At the theatres, of course, the language difficulty precludes a stranger from following the plays with any great interest. In fact, this difficulty is met with everywhere when one wishes to see Russia not purely from the tourist's point of view, but so as to find an interest in the real life of the people. It is impossible to learn sufficient of the language in a few weeks to be able to understand what is being said by those one meets casually. At the most one learns a few expressions—to call the waiter "You person, you," to refer to the chambermaid as "the female creature," the coachman as "the little liar," and the man who sells cigars on the street as "little smoke stack." For all that, one can derive much benefit from even a casual visit. The hospitals are everywhere well worth inspection. Some of them, like the Imperial Gynæcological Clinic, are palatial and imposing structures that need fear no comparison with similar institutions anywhere in Europe. What is particularly striking to the man who comes to Russia under the impression that hospitals are unknown here, is the sight of a hospital in every small town. These village hospitals are of the cottage hospital class, and some of them are very old. They are not all equally good or equally well-equipped, but they serve their purpose quite efficiently. A feature in the hospitals is the comparatively small amount of space given to isolation quarters. In the newer German institutions the isolation blocks are usually large and imposing, but it is difficult to see what good purpose they serve. During ordinary times the beds are unoccupied, and in epidemics the accommodation would be quite insufficient. Another good point in the Russian institutions is the lavatory arrangements, which are really excellent. All the hospitals stand in their own grounds, and are, in fact, little kingdoms, which are entirely outside the control of the city officials. This is due to the fact that all Russian hospitals are under a special board, at the head of which is, nominally, the Emperor, though practically the head is the permanent "Chief of Hospital Control for All the Russias," who is an experienced medical man. Associated with him are both medical and lay men, so that every subdivision is adequately represented. This board has jurisdiction over all the hospitals; it confirms appointments, authorises expenditure, approves plans and specifications, and ratifies any rules which the local director may draw up. So far, I am told, the centralisation has worked well—much better, in fact, than in France, where the permanent head is a layman, and where the relations between the directors of individual hospitals and the officials responsible for funds, etc., are not always of the smoothest. The majority of Russian hospitals are divided into departments, each of which is under a separate head, though the director, who is supreme, controls both the administrative and the medical department. At the meetings of the hospital board, which has to report periodically to the central authority, the dean of the staff presides, and not, as in Germany, the head of the medical department, who may be junior to his colleagues.

The interior of the hospitals is, on the whole, very satisfactory. To a Guy's man, with vivid memories of the horrors of Isolation and the ventilation of Out-patients, the wards are really handsome, although they are not quite so perfect as the newest German institutions at Greifswald and St. George, Hamburg. The floors are usually linoleum, the beds neat iron structures. In some wards there are cheerful open wood fires; others are heated by Russian stoves. The ward is usually decorated with pictures of the royal family and an *ikon* or two, but in the larger hospitals superfluous addenda have been eliminated, to ensure greater cleanliness, and there are comparatively few fixtures to the floor or wall. The day rooms are large and airy, and have a balcony attached. The operating theatres are, on the whole, small, but quite up to date. In a few the lighting is very good. In the medical wards one notices the diagnosis writ large above each bed, usually in Latin, and sometimes a trifle ludicrous. Thus the following can hardly be equalled anywhere—"Potator strenuus—onychophagus—cor. dil. —emphysema pulmonis—adipositas." It reminds one of our "symptom diagnoses."

Turning to the purely clinical side of the surgical department, the first thing that strikes one is the comparatively large use of medicines in the surgical wards. Aspirin is frequently ordered, and, in the case of children, relatively large doses (as much as twelve grains) are prescribed. The expensive argyrol, protargol and cinnamates are used, while hydrogen peroxide is largely favoured. Syphilitic patients receive inunctions, which are very efficient, and are not open to the objections which are valid against intra-muscular injections, a method which should be very cautiously employed, especially in children. An interesting point to me was the prescribing of formates, chiefly those of calcium and lithium, in cases of osteo-arthritis and rheumatic joints. Formates are undoubtedly very useful adjuncts in the treatment of cases of debility, and in nervous conditions (such as the distrophics and the muscular contractures after enteric), and in Italy they are used in cases of pellagra. Their use in rheumatic conditions is, however, due to a curious mistake. The popular notion that a bee's sting is a good remedy against the "rheumatiz" was elaborated by some ingenious physician, who argued that, as formic acid is the active principle in bee venom, the use of the formates might do good in such cases. Formic acid is, however, not found in bee poison. Langer has proved that the active principle is an alkaloidal substance, and has isolated this, in the shape of tiny white

needle-shaped crystals. At Tubingen, I believe, experiments are now being carried on to find out whether subcutaneous injections of a dilute solution of this poison have any effect upon cases of rheumatic arthritis, but the results have not yet been published. Serums are largely used, and are said to be very effective. Thus, at Warsaw, many cases of bad tetanus have been saved by the injection of the antitoxin directly into the spinal canal by means of lumbar puncture. When one considers that similar good results are claimed for the intra-arachnoid injection of magnesium sulphate solutions in this condition, one is rather sceptical as to whether or not all these cures are really due to the injections. In pure surgery the Russian novelties are chiefly modifications of already existing methods. In one line, however—transplantations of joints—Russian surgeons have taken the lead. They have successfully "transplanted" the knee joint, and one of the most interesting cases was the transplantation of a tarsal joint into the excised elbow joint. The patient, a girl of twenty-one, with extensive tubercular change in the left elbow joint, had been treated successfully some years ago by conservative methods, but her elbow had ankylosed in an extremely awkward and inconvenient position, so that she was practically deprived of the use of her left hand. The joint was excised, and at the same time the first metatarsal phalangeal joint of the left foot was completely excised, without being opened, and transplanted into the excised elbow cavity. The result was a splendid proof of the practical usefulness of the method. The girl made a rapid recovery, and is now able to use her left hand quite well, all the elbow movements being normal, with the exception of extension, which is still somewhat impaired. A, to me, novel method of treating tuberculous joints was the method of deeply cauterising them. The child is anæsthetised, and the foot (to take a case of caries of the tarsus) cleaned; the actual cautery is then thrust deeply through the sodden tuberculous tissue down to the bone in various directions, care being taken not to make the punctures, which must be deep and deliberate, too close together, to avoid the risk of gangrene. It is claimed that by this method cicatricial contraction is unusually strong, and healing is rapid. I saw several cases which had been so treated, but could not satisfy myself that the results were in any way better than what I had seen at Berlin at Klapp's clinic, where conservative methods and hyperæmia are used. The joints are all stiff, and in many cases the scar tissue is again breaking down; in addition, the method is a very painful one, the applications of the cautery have to be repeated weekly, and after each sitting the little patient has to receive a morphia injection. Orthopædics is not so thoroughly understood here as in Germany and Italy, or France. It is still regarded as belonging to the general surgeon, as with us, and the results are no better than in England. Thus at one out-patient department can still be found the inane and mischievous treatment of flat-foot by exercises which are supposed to restore the arch, but which really make the condition worse. Equally bad are the tenotomies, the tendons being still, as with us, cut more or less completely through, and thereby seriously weakened. On the other hand, general surgery has reached a very high standard of excellence. The abdominal operations one sees are characterised by the speed with which they are executed, and by the use of interrupted sutures, which are also much used in Germany. An expert operator working with interrupted sutures is as quick as one of our men using the continuous, and the advantages of using interrupted stitches are not wholly theoretical, although one can readily admit that the dangers of the continuous method are exaggerated. In children, where rapid intestinal work is the first consideration, the continuous suture has certainly great advantages over the interrupted. Intestine junctions are done by the invagination method, a neat and quick way, or, more usually, by lateral suture and opening. For herniæ (which are very common, many of them being "purposely acquired" by dilatation of the canal by means of the finger, to escape military service) the usual operation is the Bassini, though Kocher's third method is becoming popular. MacEwen's operation is, however, known and sometimes done. In the after treatment of abdominal cases, care is taken in maintaining the position, which is usually slightly raised. Strychnine is not to be found in the surgical wards; it has been wholly replaced by camphor, which in its turn is giving way to the excellent digalen. Ergot and adrenalin have been used, but have been given up, because their effects are transient, and the latter has been the cause, it is stated, of capillary oozing after hernia operations, giving rise to troublesome hæmatomata. Infusion is largely employed, it being usually intra-cellular; intravenous injections are condemned as bad, and in many cases quite useless. Rectal infusion is also largely employed, and is very highly spoken of. Many of the operations undertaken are severe ones, the justification of which is perhaps open to discussion, as the cases are very far advanced. There are two sides to every question, however, and one can only agree with the main principle that the first duty of the surgeon is to his patient, and that his reputation or his mortality figure is only a secondary consideration. For all that, so severe an operation as that of Lennander raises some doubts as to whether this principle is to be honoured in every case. In this operation Poupart's ligament is divided at its attachments, and the incision, which is made more or less parallel to its fibres, is prolonged outwards, backwards and upwards. The anterior abdominal wall is thus loosened, and the peritoneum exposed. This latter is pushed upwards, laying free the large vessels, and so enabling the surgeon to gain access to the deep lumbar glands, and to remove all the chains, including those lying along the abdominal aorta. When all have been taken away, the ligament is carefully sutured down again, and the flap as carefully joined, no drain being inserted. In cases of advanced carcinoma, such an operation is exceedingly difficult, and is scarcely of much use.

Equally up to date are the methods of diagnosis used in the surgical clinics. Thus in cases of pancreatic possibilities the sugar reaction is carefully estimated,

the patient being starved for a day and then given a large amount of pure glucose, the control test being undertaken by an assistant upon himself. Sahli's glutoid test is also much used, though the old Sahli test (the salol reaction) and the Cammidge tests have been given up as uncertain. In this the practice agrees very closely with what is followed in Germany, where the Cammidge test is regarded as too complicated and not giving such good results as the iodine test, the meat test, or the methylene blue reaction. In stomach cases, where there is a doubt as to the presence of carcinoma, the Salkowski reaction is used along with the usual examinations of the stomach contents. The newer signs are all known and looked out for, and one novelty, to me, was the demonstration of the well-known Trendelenburg's sign, which I had hitherto only associated with coxa vara and congenital luxation, in a very well-marked case of sacro-iliac disease. The professors and assistants nearly all speak German, and many of them French as well. Some speak English also, and on the whole English literature seems to be well known. Thus a demonstration of a condition I had never before seen—that rare lesion described as "duodenal emphysema"—led to a short talk about the frequency of duodenal lesions generally in surgical practice, and the professor referred to "the statistics of your surgeon Perier"—pronouncing the name as if it were French. This I found referred to Sir Cooper and Dr. Shaw's work, although at first the reference was by no means obvious. Such mispronunciations, however, are no more amusing than the custom which prevails in England of mis-spelling and mis-pronouncing foreign names, and one can only wonder what the gentlemen in question would think of "*Cocker's* operation," "*Giggly's* saw," and "the veins of *Sappy*." The most ludicrous mistake must, however, be debited to the editor of a German professional paper, who, when a prominent English surgeon published a pamphlet entitled, "Remarks on cases of Fractures of the Vault of the Skull," stated in a news paragraph that "An interesting contribution relative to the frequency of cranial lesions from the pen of Mr. Remarks, a London colleague, . . . has reached us. Remarks supposes . . . ," &c. An equally amusing mistake was recently made in an American paper which referred to "the large orthopædic establishment at Codavilla in Italy." It is quite true that the finest orthopædic hospital in the world exists in Italy (the Instituto Rissoli at Bologna), but Signor Codavilla happens to be the senior surgeon of the place. On the whole, however, it is remarkable to find how accurately English names are given in Continental literature, and how well certain professors are acquainted with what has been done in England in their specialities. Professor Kraus at Berlin, for example, appears to follow the advances in England attentively, and in his lectures nearly always has a reference or two, mainly to the Edinburgh School, however. At Prague, where Talma's operation is very frequently done, the professors know all about Rolleston and Hale White's theories, and, what was still more striking, were also acquainted with the contributions made to the subject by the Dutch surgeons, such as Rotgans and the Utrecht professors.

At the Russian hospitals the porter is an institution of as much importance nearly as the director. He is gorgeously attired, and on feast days (and there happens to be a feast day nearly every week—a great nuisance, as such days are public holidays, and one cannot properly visit the clinics) his costume is as ridiculous as that of a University Chancellor or a Knight of the Garter with his egrets' feathers. This individual lodges, like Cerberus, in a small house, which guards the entrance, and as he is very imposing, very morose, and knows only Russian, it seemed at first a matter of some difficulty to pass him. Unless one has an obvious and tangible lesion, he does not permit one to enter the sacred precincts, and a visiting card is contemptuously disregarded. He stands before you, stroking his patriarchal black beard, a towering figure of a man, with the dignity of a chief justice and the stolidity of a Cretin, and pours out a string of questions, which are of course utterly incomprehensible to the unfortunate visitor who does not know Russian. A five kopeck piece, however, brings a sudden and startling change, and his plumed hat descends gracefully while "your little honourableness" is invited to step inside. After that all is plain sailing. You find your Russian colleagues to whom you have introductions the most utterly good fellows in the world, while those to whom you are a complete stranger are no less courteous and obliging. They seem to regard it as an honour to them, not as a privilege to you, to show you round and explain things, and they are always eager to hear what is the practice in England, or how would this or that case have been treated in Berlin or Paris. As a matter of fact, they probably know quite well what the practice is at Paris or Berlin, for most of them are travelled men, and their wards give ample proof of the fact that they have tried to compare methods and have adopted the best. For instance, spinal anæsthesia and local analgesia are largely replacing chloroform and ether. Ethyl chloride is, however, still largely used, although there have been a few deaths under it. It is given by the open and dreadfully wasteful method, and appears to be scarcely an ideal anæsthetic. Nevertheless, it is employed in many operations where we, or the Berlin folk, would use ether or a local anæsthetic. I was very much struck with the excellent results obtained in the treatment of anal strictures and rectal contractions (mostly gonorrhœal) by means of icthyol tampons. A 10 per cent. solution of icthyol is used, and the improvement is rapid and permanent. The inunction treatment of syphilitic patients, already alluded to, was also interesting. In Germany this method has fallen into abeyance somewhat, and the uretic gonitis in children is treated by means of sublimate baths (0.5 gramme sublimate to each bath) several times a day. Inunction seems to act much quicker when combined with suitable internal medication. A few cases of bad rheumatic joints were to be seen, for which aspirin was given: one assistant was very keen on taking cultures to search for "Schüller's bacillus." A good

many excellent nerve cases, suitable for surgical treatment, were to be seen, but they were only treated electrically. The more one sees of such cases, the more one wonders why the excellent results of Spitzy, one of the pioneers of modern nerve surgery, have not stimulated surgeons to deal more radically with these cases. So far, I have only seen one case of a nerve lesion treated by surgical measures, and in that the operation, largely owing to faults in technique, could scarcely be called a success. I am therefore looking forward to seeing the results of Dr. Spitzy's work, and to compare his methods with those I have had an opportunity of seeing in Paris and at Milan. The main objection to earlier interference appears to be the difficulty of foretelling in what condition the nerve implicated will be found, while in late cases it is stated that the results are uniformly bad. This is far from being the case. The ulnar nerve, for example, has been successfully treated by secondary suture and resection eighteen months after the original injury, and Spitzy's brilliant successes in cases of Erb's paralysis and spastic diplegia are generally admitted. For all that, surgeons seem chary of following on his lines. At Berlin, for example, I saw many tendon translantations, but no nerve transplantation, and the results tendon transplanting which I have so far seen, both here and in England, are by no means encouraging. Where the result is good, it is open to doubt whether this success is due to the operation or not. Much more often such cases would have shown an equally good result under proper conservative orthopædic treatment.

At Out-patients one has a chance of seeing many common conditions, and contrasting the methods used for their relief with those which are honoured at Guy's. The obstinate ulcer of the legs—that great bore of the strapping room—is very summarily dealt with. A circular incision is made a hand's breadth above it, dividing the superficial veins and nerves, and thus depriving it of its surface nutrition. Then a dressing of Peruvian balsam is applied, and over that an Unna's bandage. Where the ulceration is very deep it is refreshed and grafted. The cases seem to do well, but a great deal of care is necessary, and one doubts if such good results could be obtained in London, where the dressers so frequently change and where one H.-S. rarely has charge of a case long enough to see it right through. In bad carbuncles, zinc chloride, made into a thin paste, is applied. It is very painful at first, but gives an excellent scab, and all the cases do well. At Berlin, hyperæmia by suction is used, combined with small incisions. Excision is generally condemned as being too drastic, and, internally, cod-liver oil and malt (and not calcium) are given, with frequent small doses of calomel. The calomel is regarded as a good diuretic, and the objections to using it in septic cases are met by giving it in very small doses. The treatment of diabetic gangrene, which appears to be relatively frequent, is usually expectant. When, in spite of rigid dieting, the percentage of sugar in the urine increases, and the pains become worse (diabetic gangrene is usually a painful lesion), immediate amputation is done, but the prognosis is then necessarily a very grave one. A good deal of work has lately been done on the subject of diabetes in general, and the gangrene associated with it in particular. Thus it has been found that it is practically impossible to produce diabetes or glycosuria by any of the usual methods in a thyroidectomised animal; even complete extirpation of the pancreas, combined with damage to the semilunar ganglia and puncture at the diabetic point, has failed to render the animal diabetic. This result has been taken up by several experimenters, who are trying to throw some new light on the matter by further research. An interesting case brought to Out-patients at one hospital was a small boy with retention of urine and severe pain. It was found that he had jumped down from a height and landed on his abdomen. He was taken in, and on examination a fracture of the pelvis was found, with extra-peritoneal rupture of the bladder, the urethra being apparently uninjured. At Guy's we have a somewhat similar case recorded in one of the Museum specimens (I believe, No. 1752), in which the patient was thrown over Blackfriars Bridge. This proved to be the fourth case of ruptured bladder I had seen since January last. Another very interesting case was a woman of forty-three, with an exceedingly large tongue. I thought the case was one of macroglossia (as, in fact, literally it was), but the condition was not quite identical with that usually described as macroglossia. In pure macroglossia, as Mr. Symonds teaches (I have never seen a case), the affection is congenital in more than 60 per cent. and apparently congenital in 30 per cent.; it is usually a long-standing condition, associated with recurrent attacks of glossitis, and with a peculiar pressure effect upon the jaws, best shown in the "lie" of the upper teeth. In this case the woman declared that her tongue began to swell about six months ago; leukoplakia was marked, and the tongue appeared hard, without being definitely nodular at any point.

The condition was exceedingly puzzling, there being apparently no pain or tenderness. Remembering a stray passage in Mr. Butlin's book, I made a shot at "syphilitic macroglossia," and was told that the swelling was going down under anti-luetic treatment. Syphilis of the tongue is, however, more usually associated with atrophy than with hypertrophy, but I was told that this form is well-known, and has been described by Fournier. So far as I can remember, it is not mentioned in any of our text books, although gummata of the tongue are, of course, known to every student. Another out-of-the-way case, was a child with what is called "Phokomelia"—congenital absence of the femur, a condition easy to spot, but by no means easy to treat. With supporting apparatus, this patient manages to get along quite well. Much more interesting was a young woman of twenty-eight, with what was undoubtedly an axillary carcinoma—that is, carcinoma of the outlying portion of the mammary gland, lying within what is really the axilla. This is the youngest case of carcinoma of the breast proper I have seen, but I am told here that such conditions appear on the whole to be met with in relatively younger patients than is the case farther west. Thus from Odessa has been recorded a case of mammary carcinoma in a girl of

ten, and penile carcinoma in a child of three. In Mr. Birkett's article in the old Holmes' system, the case of Lyford is mentioned—mammary carcinoma in a girl of eight—while in Bart.'s museum there is a specimen of mammary cancer from a girl of sixteen. Such cases must, however, be exceptional, and at Guy's the average age is certainly well above thirty.

My experience of Russian hospitals has made me keen to see more of them. At St. Petersburg, as Professor Kuttner told me, there are some very fine institutions, and regular post-graduate courses, which are practically free, are given all the year round. At Moscow there is one hospital which is entirely devoted to graduate study—the Imperial Gynæcological Clinic. Here practitioners can take a house appointment, and brush up their midwifery by paying a nominal sum, and courses, which are very popular, are given. A good deal of pathological experimental work is done. In fact, post-graduate teaching in Russia is on a much better footing than with us.

Vienna. C. L. L.

Change of Address.

H. Charles Cameron, M.B., from The College, Guy's Hospital, to 6, St. Thomas's Street, London Bridge, S.E. Telephone 2087 Hop.

Dr. John Evans, from 6, Caroline Place, London, W.C., to 18, London Road, Neath, Glam.

Major C. M. Fleury, R.A.M.C., from Clonmel to Malta.

Mr. E. C. Hughes, M.C., from Guy's Hospital to 6, St. Thomas's Street, London Bridge, S.E. (from October 1st). Telephone 2087 Hop.

L. J. John Orpen, M.A., M.B., B.Ch. Oxon., from the Infirmary, East Dulwich Grove, S.E., to Salisbury, Rhodesia.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Papers by Guy's Men.

Measles as a Cause of Death in the Puerperium. By T. Reuell Atkinson.—*British Medical Journal*, August 15th, 1908.

Observations on Pulmonary Ventilation in Disease. By A. P. Beddard, M.D., and M. S. Pembrey, M.D.—*Ibid.*, August 29th, 1908.

A Case of Congenital Hypertrophic Stenosis Treated Medically. By Norton B. Clowes, M.R.C.S. Eng., L.R.C.P.—*The Lancet*, August 22nd, 1908.

The Examination of Water on Field Service. By Captain R. Tilbury Brown, M.D., R.A.M.C.—*Journal of the Royal Army Medical Corps.*

Two Cases of Acute Pyorrhœa Alveolaris Treated by a Specific Vaccine. By Kenneth W. Goadby, M.R.C.S., L.D.S.—*British Medical Journal*, August 22nd, 1908.

Appointments.

Civil.

BARRON, R. D., M.R.C.S., L.R.C.P., has been appointed Vaccinator for the District of Opunake, N.Z.

GREENING, W. R., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Second Resident Assistant Medical Officer to the St. George's Union Infirmary.

ORPEN, L. J. JOHN, M.A., M.B., B.Ch. Oxon., has been appointed Medical Officer of Health for Rhodesia.

ROTHENBERG, A. H., has been appointed Hon. Dental Surgeon to Masterton Hospital, N.Z.

Naval and Military.

Surgeon HAROLD G. T. MAJOR, R.N., has been appointed to the *Spanker*, and Surgeon AUGUSTUS J. WERNET, R.N., to the *Majestic*.

Lieutenant PERCY S. MILLS, M.B., I.M.S., has been appointed a Specialist in Ophthalmology for the Rawal Pindi Division, India.

From the Gazette's Special Pathologist.

J. C., MARKET HARBOROUGH.—This specimen consists of skin, cicatricial tissue, fat and muscle, with occasional inflammatory areas. We find no evidence of a recurrence of the original growth.

R. F., BROADBOTTOM.—These fragments present the appearances of a cervical erosion with much inflammatory change around the glands. There is no evidence whatever of a malignant growth.

H. B., MITCHAM.—No tubercle bacilli are detected in specially-stained preparations taken from the centrifugalised deposit of this urine. PATHOLOGIST.

Birth.

STEVENS.—On August 23rd, at "Knottsall," Ealing Road, Wembley, Middlesex, the wife of John Stevens, L.D.S. Eng., of a son.

Marriage.

GODSON—EVANS.—On the 26th August, at Bowdon Parish Church, by the Rev. R. E. Roberts, M.A., Francis Arthur Godson, M.B., B.C. Cantab., Pinehurst, Didsbury, third son of Alfred Godson, M.B., M.C. Cantab., Cheadle, Cheshire, to Alice Frances, elder daughter of Thomas Evans, Bowdon.

Deaths.

CLAGUE.—On August 23rd, at Crofton, Castletown, Isle of Man, John Clague, M.R.C.S. Eng., L.R.C.P. Lond., L.S.A., aged 65 years.

OLDHAM.—On the 30th August, Montague Williams Oldham, M.R.C.S., L.R.C.P. Lond., M.D. Brux., M.S.A., for eleven years hon. surgeon, Mansfield Hospital, late surgeon Coventry Dispensary, and house surgeon Burton-on-Trent Infirmary, aged 46.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

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Welcome!

IT is, indeed, a pleasant duty which yearly devolves upon the writer of these columns, —that of addressing a few words of welcome to those men who are about to join us. Following custom, these words usually head what for years has been known as the Special Students' Number, a number devoted to an outline of the course of studies to be pursued, and a list of the various constituent student institutions. Taken in conjunction with the Green and Blue Books—which no doubt the Medical School Office has already provided you with—we trust it will be of some use.

Doubtlessly many considerations may have led to your becoming a disciple of Æsculapius. Maybe in the prattle of your childhood's days you gave some early sign of a penchant for medicine, the desire being innate and growing stronger as you reached more mature years; then verily may we say that you have adopted a vocation—a vocation in the sense that you feel you have been *called* to your work. Or perhaps you are the descendant of a series of medicos, and, willy-nilly, it is a doctor you are to become; yet again your reason may be simply to gratify parental wishes. Whichever it be, here you are, and may we congratulate you on your choice, not only of your Profession, but also of your Medical School.

We take it for granted that you have entered the portals of medicine with your minds fully acquainted with its advantages and disadvantages. Of late, the lay papers have drawn much attention to the material recompenses of a doctor. If you have followed these "silly season" discussions, you will be disillusioned as regards little work and fabulous wealth. No, the profession is one to which application is essential. Of course, you have an understanding of the beauties of your future labour, a labour which is noble in every trait. To care for and prolong human life, to dispel suffering and sorrow, and to ever seek Truth in all things—such are its aims. These, well done, are compensations as great and greater than mere gold. The life is one of ever-increasing interest and usefulness. Your daily contact with humanity —a kaleidoscopic procession of beings brought on to a common plane by suffering—will teach you Life, with a big capital L. Year by year you will realise these things, and will thank Providence that you have chosen so wisely.

It is only natural that for some few days your new associates and environment will make you feel a little strange. But it is remarkable how quickly that passes off. Several of you may be

'Varsity men, and find friends and men from your College already here. You may feel that Guy's is but a minor shrine—that your College, with its great traditions, is your real Alma Mater. Then slowly and surely that great Unseen Force, the *genius loci* will work wonders. It will co-operate you all, weld you into body, coherent and strong, in which the linking force is an esprit de corps of traditional fame. In a fews words you will be Guy's men, and you will worship at one shrine only.

What are the factors which have conduced to this powerful esprit de corps? Briefly may they be chronicled—good work and good play. In both you are helped to the utmost by your choice of Medical School. You have the material at hand, and it is for you to make your own career. Too much devotion to the one or the other must perforce lead to disaster. The old trite adage, "All work and no play, etc.," is only too true. What do medals and scholarships avail if your constitution is damaged beyond repair for lack of sufficient exercise? And, again, on the other hand, too much play and no work makes Jack a very dull boy; so steer a middle course and temper your studies with healthy exercises.

As regards your work, the first year or so is filled to overflowing with subjects which seem to have but a too small direct bearing on your future work. But they educate the scientific spirit, and of all things in medicine that is the spirit to be fostered; yet still again—and maybe more important—the examiners require a certain knowledge of the Syllabus, so we are afraid this year's work will demand a great deal of your attention. You will find it interesting, especially if you attend to its practical side; therefore bear in mind the laboratory work. Lectures have to be attended, the powers that be—the examining bodies—have ordained it; if you "cut" them, remember *you* are the loser; in your later years, when you are in the wards, any similar neglect of your duties will not only recoil upon yourself, but also upon your patients; so do not cultivate this "cutting" habit.

As regards recreation, as members of the Clubs' Union, you are singularly well off. In the field of Athletics there are the Rugby and Association Football Clubs, Cricket, Hockey, Golf, Swimming, Cross-country, Boxing, Gymnastics, and Athletic Associations At Honor Oak Park, easy of access—acquaint yourselves early with this fact—we are the proud possessors of a magnificent ground. The Debating, Physical, and Dental Societies will afford you opportunities to distinguish yourself either as a good speaker or a good listener; do not let the fact of your being a new arrival hinder you from attending the meetings of these societies; you will be always welcome.

One thing we assure you, and that is, before being long here the love which the dear old place instils into all will come to you, and as the years pass by—all too quickly—you will realize what a great hold it gets of one. Then will you understand that sigh of regret, which men qualified and about to go out into the world give when they tell you that "It's jolly hard to have to leave the old place."

Once again we bid you welcome, and hope that your student days will be days of good work and much happiness; that the fund of experience which you will acquire will develop your sense of sympathy and justice, and that when the time comes for you to leave, you will ever think of your Hospital with that love which characterises all old Guy's men.

Papers by Guy's Men.

With Mr. R. H. Jocelyn Swan in the Out-patient Department of the Cancer Hospital.—*The Clinical Journal*, 16th September, 1908.

A Case of Foreign Body in the Left Bronchus. By H. A. Moffat, F.R.C.S. Eng.—*The Lancet*, 5th September, 1908.

Untersuchungen über das Verhalten des Vestibular apparates bei nicht eitrigen Erkrankungen des Ohres. By Norman H. Pike, M.B., B.S. Lond.—*Monatsschrift für Ohrenheilkunde.*

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the Gazette *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated.*

Passim.

THE present number of the GAZETTE, which is the last issue during the Summer Vacation, is, in accordance with a good custom, devoted to the needs of the new student. An attempt is made to combine exhortation, advice, and information in such proportions that the freshman may be guided without being bored, and in such a way as to supplement that other publication intended for his guidance — the Hospital Green Book.

To senior men the Green Book presents little novelty, but most of them can remember studying it sedulously enough at one time or another. Although, indeed, there is little scope for novelty in its pages, yet there are some changes in this year's issue, which are both of interest and importance, and it may be worth while to draw attention to them. The Vaccine department is given a place, for the first time, in the account of the hospital practice; in addition, it is announced that a special department for diseases of the genito-urinary system is to be instituted. As regards changes in the classes, it is to be noted that the Microscopical Pathology class is now to be held twice a year, and that the course in Operative Surgery is now uniform for Conjoint and for University students, with the exception that for the former the demonstrations are optional. The Greville Research Scholarship for investigation of "Some of the Problems connected with Cancer," and the Oldham Prize in Ophthalmology, figure for the first time among the list of Scholarships and Prizes.

THE new curriculum issued by the London University will be welcomed on all sides. A step in the right direction has been taken, and we trust it will prove the precursor of many similar steps in the revision of the course of studies in the early years of medical studentship. The march of knowledge has necessitated that the teaching of the pure sciences should be of such a nature that it will be of maximum use in the future work of the student. To this end the newly-framed curriculum is directed, and in its new form the knowledge acquired in the first year will far better provide for the requirements of second and third years' studies than hitherto.

IT may not be out of place here to remind the secretaries of the various clubs and societies that they will greatly assist the Editor if they will undertake to send in their reports of meetings and matches by the Tuesday evening preceding each issue. The reports of last year's fixtures were of a fairly high standard, but we assure them that there is still scope for more ambitious efforts, and that any assistance which they may desire, in the way of reporting, the Editor will be pleased to give them if they apply at a sufficiently early date.

OLD Guy's men should read with interest a letter, anent the Blue Book, from Dr. H. C. Mann, Honorary Secretary of the Clubs' Union, which appears in another column. The idea of forming branch secretaries in various parts of the world cannot fail to make the publication more interesting. All men, on receipt of their Book, should hasten to fill in and return the pink inset, and should give as much information about themselves as they would like to hear of their friends. Remember what a link this will constitute between you and the men in your year. We congratulate Dr. Mann on his fine work in the interest of the Clubs' Union, and trust that his efforts will meet with the success they deserve.

ONCE more we venture to draw our readers' attention to the first meeting of the Physical Society, to be held on October 8th. At the dinner, which takes place in the Dining Hall, at 6.25 p.m., Mr. Cosmo Bonsor will preside, whilst at the meeting Sir R. Douglas Powell will deliver an address, "A Just Perspective of Medicine." Dr. Goodhart has kindly consented to take the chair. It is hoped that this year men will turn up in great force and do honour to the distinguished speaker. Tickets for the dinner (3s. 6d. each), may be obtained from the Hon. Secretaries, Mr. Mollison and Mr. Nicholson, also from any of the Presidents, and at the Desk.

The usual exhibits of interest to medical men will be on view in the museum after the lecture. Among these, we hear that Messrs. Ash & Co., Ltd., are giving a demonstration of copperplate and photogravure printing, and will present an appropriate souvenir of the occasion to all those present.

It is hoped that many old Guy's men will pratronise the Society's evenings. They are cordially invited to take part in the discussions, and to show specimens at the Pathological evenings. They should, in any matter relating to the Society, address themselves to the Secretaries, who will also be pleased to forward them tickets for the dinner, and make every arrangement to place old friends together.

By common consent, the old rule that members of the Clubs' Union should produce their cards of membership—the Fixture List—on seeking admission to the ground at Honor Oak Park, during the progress of Football or Cricket matches, has fallen into neglect. Doubtless this old rule was seldom adhered to, as most men are known to the gatekeepers; nevertheless, we think that, in the interest of the Clubs' Union, it should be enforced. All that is necessary is for men to purchase a Fixture Card. In this way all mistakes can be avoided.

Appointments.

Civil.

Fagge, R. Hilton, L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer, Workhouse and No. 2 District, Melton Mowbray Union, and Medical Officer, Post Office, Melton District.

Isaac, B., L.R.C.P. Edin., M.R.C.S., has been appointed Medical Officer of Health to the Uwchaled Rural District.

Jupp, E. Norman, L.R.C.P. Lond., M.R.C.S., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Chard District of the County of Somerset.

Shorland, E. T., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of Health to the Westbury Urban District.

Soper, A. W., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer, Anerley School, North Surrey School District.

Turner, T., M.B., B.S. Lond., L.R.C.P., M.R.C.S., has been appointed Senior House-Surgeon and Senior Resident at the Sunderland Infirmary,

The Nature of Holidays.

By the Writer of Confessio Medici.

This I know, that the nature of holidays evades all measurement. Neither psychology, nor science, can help us here. We might as well hope to understand what happens to a man when he passes from the noise and crowd of the streets into the silence of his own room, or into the presence of music. As it is with silence, and with music, so it is with holidays; we have, or we have not, the love of them. Silence appeals, to him who loves her, with all the importunity of a physical sense. Music, for lovers of music, beats and shakes with both hands the shutters of the house of life, till they are flung wide. Holidays are no less masterful; they call us to surrender, to come out of our built-up habits; and we talk vaguely of a man taking a holiday, whereas the holiday takes the man.

Time enough to explain the influence of holidays, when we have explained these other influences, of silence and of music. Nothing, in all the slipshod ways of popular thought, is more gross than the notion that our loves are explicable; and the love of holidays will remain to the end of time as great a mystery as the love of a man for a maid. Indeed, since the world began to be made, nothing has explained anything, and nobody has explained anybody. If explanations ever become final or complete, the world will immediately stop being made: and Chaos will be left to the congenial task of explaining itself. There is no room, on this full and urgent little planet, for any facts but miracles, no time for any sentiment but wonder: and wonder, says Aristotle—and he ought to know—is the first principle of philosophy. Let us, therefore, put aside all attempts to discover how holidays act on us. They are just the wedding of one miracle, which we call self, with another, which we call Switzerland, or the sea-side, or Italy, as the case may be. It would take a fool of no ordinary dimensions to estimate the workings of such an union.

Consider, as a proof of the impossibility of arguing about holidays, the common phrases which we use concerning them. *I am run down, I am slack, I want picking-up, I want recreation, a change, a time off.* These and the like phrases go upward, like Jacob's ladder. But the hyphen has fallen out of the word *recreation:* whereby the ladder has lost one of its rungs. Put back

the hyphen, and you get an ascending scale of words that are, practically, words of religion. To be quickened, raised, born again, converted, set free—who would thus describe the taking of a holiday? Yet there the words are, with hardly a touch of translation. Our holidays are ourselves enjoying ourselves: and Jacob was not the only young man who has felt the profound significance of camping-out all alone.

To be alone, is the way to obtain dreams and visions, without which a holiday cannot be really successful. But, of course, you can be alone with a friend on either hand, if they are of the right sort; you can even be alone with fourteen people in a railway compartment made for twelve—if they have no refreshments with them. Anyhow, in the spirit, if not in the body, you must be mostly alone. Yet, at the end of each day, after dinner or supper, crown your loneliness with company.

Get your thoughts, on a holiday, out of yourself, and out of your surroundings; which, in a very true sense, are also yourself. Be careful not to get them out of books. Do not be anxious to improve your mind; be content to let your mind improve you. I should not be giving this dangerous advice if I believed that our minds are our brains; but I am sure that they are not.

It has been said that a holiday need be nothing more than a "change of occupation." That is a very bitter doctrine: it may be true, but I hope that it contains a sweetening dash of falsehood. To be occupied on Monday with out-patients, and on Tuesday with the Lake of Lucerne, is more than a change of occupation. We might more accurately use the old word *re-creation*. Let us accept, though we need not formally declare, the plain fact, that the influences of a holiday are spiritual. Our holidays are ourselves; but we did not make ourselves, and we do not make our holidays: it is they that make us.

As in the first creation of us, so in the re-creation of us, there is reversion to a simpler type, a lower form of life. On a really good holiday, we revert. We sleep more, talk less, go bare-headed, and eat whatever comes handy. Some walk all day for the mere pleasure of the movement: some indulge the instinct for killing: some take to the sea, some to the mountains. We all tend to be (O! lovely phrase) less highly differentiated: *to go back, a few miles, a few weeks, toward Nature.* We are not likely to get far on that road: a month is not long against so many centuries.

But, if this were all—if holidays were no more than a return to the behaviour of our arboreal or tribal ancestors—what becomes of those milder souls, whose holidays are in foreign towns, picture-galleries, old buildings and ramshackle streets? By what theory of holidays can we identify the joy of tramping over a Yorkshire moor with the joy of sitting in Saint Mark's, Venice? Why, that is just it. There are diversities of gifts, but the same spirit. Be what we may, do what we may, the spirit has something for all of us. Only, we must let it give its gifts. He who will not do that, will never have a holiday. He drags his chain wherever he goes. His fads, his moods, his dress-clothes, parlour-tricks, London habits, club-gossip—his damnable interest in his own separate elaborateness—all so bind and hold him that the spirit has no chance of getting at him. Indeed, there is nothing, or next to nothing, at which to get.

Therefore, to have a holiday, we must be free. By that, I do not mean only that somebody else is seeing our out-patients. We must be free in the spirit, and sure that we are miracles, just shoving our way through a solid crowd of miracles, which is in every inch of the earth and every minute of the day, and as thick at Southend as at Zermatt. The smell of a pine-wood, the taste of bread and cheese, the look of the sea, the feel of the wind and the sun—miracles, all of them, alike in creation and recreation.

Papers by Guy's Men.

Pyelitis during Pregnancy.—By H. T. Hicks, F.R.C.S. Eng.—*The Practitioner*, August, 1908.

Malignant Obstruction of the Œsophagus. By Lawrie McGavin, F.R.C.S. Eng.—*Ibid.*

Presidential Address, British Dental Association, South Wales Branch. By E. H. Musgrove, L.D.S. Eng.—*British Dental Journal*, August 1st, 1908.

Case of Double Abdominal Hydrocele. By Owen Richards, M.D., M.Ch. Oxon., F.R.C.S. Eng.—*The Lancet*, August 22nd, 1908.

The Treatment of Wry-neck by Lengthening the Sterno-Mastoid. (Illustrated.)—By R. P. Rowlands, M.S. Lond., F.R.C.S. Eng.—*The Practitioner*, August, 1908.

Industrial Dermatitis. By Frank Shufflebotham, M.B., B.C. Cantab.—*British Medical Journal*, August 22nd, 1908.

Gall-Stones.

CLINICAL LECTURE BY Mr. R. P. ROWLANDS.

Gentlemen,—It is well known that gall-stones lying in the gall-bladder may give rise to no appreciable symptoms during a long life, but may remain unsuspected until after death. In a good many cases, however, troublesome symptoms, or even grave complications, may develop at any time. For the majority of these, especially when the attacks are recurrent, early operation is strongly indicated, although it is true enough that Nature may occasionally effect a cure in a variety of ways.

Delay is usually more dangerous than early operation. I wish to draw your attention to-day to some of these dangers.

A.—Stones in the Gall-Bladder.

Calculi which are too large to enter the cystic duct frequently cause no more than a dull ache in the gall-bladder region; but occasionally they induce inflammation of the gall bladder, which may suppurate, or even perforate, inducing general or local peritonitis, septicæmia, or portal pyæmia.

In other cases, the inflamed gall-bladder may become adherent to the pylorus, duodenum, or hepatic flexure of the colon. Such adhesions may allow the safe formation of fistulæ, along which stones may pass into the neighbouring intestines; or, on the other hand, they may seriously obstruct or interfere with the natural movements of the pylorus or colon. When a stone reaches the duodenum through a fistula, you know that it generally becomes impacted in the ileum, and gives rise to a very fatal form of acute intestinal obstruction, whereas, if it fortunately passes directly from the gall-bladder into the colon, there is very little danger of impaction, although a few cases are recorded in which the stone became impacted in the narrow sigmoid flexure, and simulated the symptoms of carcinomatous stricture in the same region.

The following is an interesting example of ulceration of the gall-bladder, with the formation of a fistula from it into the colon. An old lady, with a history of gall-stones, with jaundice about twenty years earlier, became very ill, with pain, tenderness, and rigidity in the right hypochondrium. She also had intermittent pyrexia, anorexia, and considerable wasting. Moreover, she passed pure bile per anum occasionally for over three months. No stone had been noticed in the stools, although carefully sought for. Dr. Lauriston Shaw saw her at her home in Wales, and advised operation. Some weeks later I saw her, and she was then a little better; the resistance and other signs of localised peritonitis had diminished, but she was still occasionally passing bile. She was only slightly jaundiced. An operation was then deemed inadvisable, because it was thought that if the fistula, which clearly existed between the gall-bladder and the colon, was due to malignant growth, as was thought probable, an operation could do no good. And if the fistula was due to simple ulceration, an operation did not seem to be wise, although the stone might still be lying in the gall-bladder above the fistula. The old lady settled the diagnosis herself by getting quite well, and remaining so for over a year now. The biliary fistula continued for several months, but no stone was ever noticed in the motions.

Primary carcinoma of the gall-bladder is not uncommon as a result of the long-continued irritation of calculi. Thus a young woman, aged 34, with a history of biliary colic for many years, developed an irregular hard swelling in the gall-bladder region, with some jaundice, severe anæmia, remittent fever, and marked wasting of some weeks' duration. The diagnosis lay between suppuration around stones in the gall-bladder and in the bile ducts, and suppuration due to growth, as well as stones, in the gall-bladder. Upon exploration, the gall-bladder was considerably thickened: it contained several gall-stones and pus; it was adherent to the liver, which contained secondary carcinomatous nodules with suppurating foci. Secondary glands in the portal fissure pressed upon the common bile duct. Had she been advised to have her stones removed some years earlier, she would probably have never developed carcinoma in the gall-bladder. The risk of cancer from chronic irritation by gall-stones is considerable, and is not sufficiently appreciated.

B.—Stones in the Cystic Duct.

Small stones in the gall-bladder frequently become impacted in the cystic duct, giving rise to the typical biliary colic associated with palpable enlargement of the gall-bladder, but without any jaundice. The last two points are very important distinctions between a stone in the cystic duct and one in the common bile duct. The latter rarely gives rise to any gall-bladder tumour, because of old adhesions and contrac-

tions of the viscus; and it gives rise to intermittent attacks of colic followed by jaundice of an intermittent type. The following cases illustrate the great difference there is between operating early and late for stones impacted in the cystic duct.

A very stout woman, aged 46, was sent by Dr. Townend, of Brockley, on February 3rd, 1907, for recurrent attacks of pains in the gall-bladder region. The first attack came eleven years ago; it was accompanied by vomiting and followed by diarrhœa. Similar attacks, but without diarrhœa, have occurred irregularly ever since; but more frequently and severely of late. She has never been jaundiced. There was an oval dull swelling below the right lobe of the liver. The gall-bladder and bile ducts were explored, the common bile duct was normal, but a stone could be felt in the cystic duct from which it could not be displaced into the gall-bladder, which was therefore excised, after the cystic duct and cystic vessels had been secured. It contained much mucus and about twenty stones, in addition to the one firmly impacted in the cystic duct. She has remained well since. A similar operation was performed on a private patient with similar symptoms, sent by Dr. Spriggs. There were over one hundred stones in the gall-bladder and cystic duct, but none in the common or hepatic ducts.

The following case of suppuration and sloughing of the gall-bladder is a striking contrast to those just related. An old woman, aged 73, was admitted into Clinical in March, 1907. She had had bilious attacks for over twenty years, and had been jaundiced after some of these. On March 2nd, 1907, she was seized with acute pain between the shoulders, radiating to the abdomen and chest. On March 5th the pain was chiefly in the right hypochondrium. On the 5th and 6th vomiting often occurred, and the temperature was 102°, the pulse 100, and a definite tender lump was felt deep to the upper half of the right rectus muscle. On March 9th, when she was admitted, the temperature was 101°, pulse 108, respiration 26.

Between this and March 14th the temperature was remittent, and the patient became drowsy; her tongue was dry and furred. The skin was dry and sallow. On March 14th the gall-bladder was isolated with gauze and opened, when much foul pus escaped, followed by a complete cast of the mucous membrane of the gall-bladder. There were so many adhesions that it was impossible to remove the greatly distended gall-bladder without opening it. Moreover, it had already perforated near the fundus, and a localised peritoneal abscess had formed between it and the colon. No stone was discovered. Drainage was established.

In spite of bronchitis she improved a good deal after the operation for about three weeks; then her symptoms recurred, and she became progressively weaker and more drowsy. On April 10th it was decided to reopen the wound to seek a possible re-collection of pus. The shell of the gall-bladder had greatly shrivelled, but within it there was about an ounce of pus, and beyond it in the cystic duct was a small stone firmly fixed. The remains of the gall-bladder and the cystic duct were therefore rapidly excised and the wound drained, but the patient died exhausted next day.

An earlier operation would have prevented the suppuration in the gall-bladder in this case, and even after pus had formed in her last illness, for which she was at last admitted into Guy's, an operation within a day or two of the onset of her symptoms would, in all probability, have been attended by success, for then the gall-bladder and cystic duct could have been excised without opening them. Weeks of pyrexia could thus have been prevented.

For sake of comparison, I may mention the case of a lady, aged 63, from whom I removed a gangrenous gall-bladder on the third day of her illness. The greatly distended gall-bladder was at the point of perforation, due to stones impacted in the cystic duct. This patient made an uninterrupted recovery.

Other things than stones may occasionally obstruct one of the bile ducts, notably small hydatid cysts. The following unusual case illustrates another rare cause: A very stout man, of 56, a coachman, was admitted into Guy's, under Sir Cooper Perry, in April, 1906. He gave a history of colic, chiefly in the right side near the liver, in March, 1905. He was said to have passed several stones then. He was free from pain from August, 1905, to January, 1906, when the pains recommenced with increased severity. Large doses of olive oil were administered, and the patient was said to have passed many gall-stones. The stools were said to have been clay-coloured. Morphia had been given frequently for the severe pain. On admission he was yellow, but not jaundiced. Pulse normal, temperature 99°. There was increased resistance and tenderness in the gall-bladder region.

Upon exploration the gall-bladder was found very adherent and distended with mucus, bu

it contained no stone. A hardness could be felt in the cystic duct, and a probe could not be passed through it into the common bile duct. The hard tissue was incised from below into the duct. It consisted of dense fibrous tissue. There were no stones in the common bile duct, which was incised for exploration. The supposed gall-stones were afterwards procured and examined, but they proved to be composed of oil and fæcal matter. The patient recovered. About eighteen months later he was heard of at a suburban hospital still passing "stones," which were probably of a similar nature.

It is probable that the fibrous stricture of the cystic duct in this case was due to the former impaction of a stone with secondary ulceration. The stone had been passed long before the duct stenosed so completely as to give rise to distension of the gall-bladder with mucus.

C.—Stones in the Common Bile Duct.

Practically all stones found in the common bile duct have formed in the gall-bladder, whence they have passed along the cystic duct, which is larger in calibre than the lower part of the common duct. It is possible that stenosis of the biliary papilla may lead to the formation of stones in a dilated and diseased common bile duct, and this may be the explanation of some "recurrent" stones in the common bile duct.

The gall-bladder, unless completely removed or disorganised, may discharge fresh stones into the common duct. In the majority of so-called recurrences, however, the stones have been overlooked at the first operation. It is not easy to find a small stone, which may have been displaced upwards into the dilated hepatic ducts, and a probe may pass a calculus placed in the pancreatic or intestinal part of the common duct. It is necessary to examine the interior of the ducts carefully with the finger.

Here I wish to lay stress upon the fact that jaundice, due to obstruction of the common bile duct by growth, is more progressive and deeper than that due to stone. Stones often fall back and allow the bile to pass for a time, so that it is characteristic for their symptoms and signs to be intermittent in type and as a rule of short duration. Therefore, colic and clay-coloured stools are often intermittent in calculous cases. It is well known that a distended gall-bladder with jaundice indicates growth rather than stone as the cause of obstruction of the common duct, the reason being that with calculi the gall-bladder is usually fibrous, adherent, and shrunken from past disease, whereas with growth interfering with the common duct, the gall-bladder may be healthy and free to expand.

With stones impacted in the common bile duct it is of vital importance to operate, if possible, before the onset of suppuration within the duct or its accessories. The prognosis of the operation, in the absence of cholangitis, is good (about 5 per cent. mortality), unless there is complete obstruction of the duct at the time of the operation; whereas, when infective cholangitis (with remittent fever) has developed, the chances of recovery are very much less (about 20 per cent. mortality).

Unless there are signs of infective cholangitis it is best to defer operation in some cases of acute complete obstruction until a remission takes place, for the mortality is then much less.

In the presence of cholangitis, and especially of chronic complete or continued complete obstruction, however, an early operation affords the only reasonable chance, in order to forestall cholæmia and exhaustion.

The following two cases illustrate some of these points, and they serve as excellent contrasts of different types.

An Anglo-Indian gentleman, aged 62, was sent to me on June 10th of this year. He had been taken ill in July, 1904, with jaundice and fever, with rigors. There was no colic; considerable wasting occurred. In November, 1904, after considerable persuasion, a well-known surgeon consented to operate, although he feared malignant disease. He removed a large stone from the common bile duct, above the duodenum; the gall-bladder was shrunken and firmly adherent, and was, therefore, not removed. The patient remained well until March 8th, 1908, when a curious feeling of nausea suddenly developed. Vomiting of a glairy yellowish fluid followed. Anorexia and wasting, suggestive of growth, have been striking symptoms since. Deep jaundice with itching skin has been present, with slight remissions, from the onset of symptoms. Many attacks of nausea have occurred, and they are often induced by taking solid food. Colic has been entirely absent.

Upon June 12th, another operation was undertaken, and a facetted stone as large as a cob-nut was removed from the dilated common duct above the duodenum. Once during the operation, which was rendered very difficult by many firm adhesions, the stone fell back into one of the hepatic ducts, where it might easily have been overlooked. After the removal of the stone, the finger within the ducts failed to find another stone in any of the bile ducts, and

a large probe passed easily into the duodenum. The gall-bladder was shrunken and empty. The common duct was drained, and another drain was placed in the right kidney-pouch. The patient has progressed satisfactorily, and is now quite well.

An elderly woman with a history of repeated attacks of biliary colic for many years, and often associated with jaundice, was admitted into Dorcas early this year. The present attack had lasted for over six weeks and had been accompanied by fever and deep jaundice. Soon after admission she became more and more drowsy, so that an operation was undertaken as a last and rather desperate resort. The liver was enlarged with extreme dilatation of its small ducts, which gave it a peculiar appearance. The gall-bladder was very small and adherent to all the surrounding viscera. Many stones were removed from a greatly distended common bile duct, but the patient never regained consciousness and died early next day.

This patient ought to have undergone operation years earlier, and in the last attack the prompt removal of the obstruction of the common duct might have saved her.

As a contrast, a lady from Margate, who was suffering from jaundice and infective cholangitis of only 14 days' duration, made a good recovery after the prompt removal of three stones from the common bile duct, followed by free drainage.

It is absolutely essential to drain the common duct after the stones have been removed. The right kidney pouch is also drained. This is the only safe way of preventing bile from leaking into the general peritoneal cavity. Moreover, drainage has a marked effect in lessening infective cholangitis and pancreatitis which so often complicate these cases.

The gall-bladder rarely needs removal in common duct cases, for it is usually shrivelled, adherent, and empty of stones, as the result of past inflammation. Even when it is capable of easy removal it is not wise to do this in grave cases, especially if there remains any doubt as to the permanent patency of the common duct throughout its course.

When the disease is strictly limited to the gall-bladder and cystic duct, things are different, for then excision of the gall-bladder is often the most satisfactory and aseptic way of getting rid of all the stones, mucus, or pus within the gall-bladder and its duct. Moreover, it prevents the recurrence of stone formation, the development of growth in the gall-bladder, or the appearance of a mucus fistula, due to the overlooking of a small stone in the cystic duct.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council :—

Clinical Assistants.—Messrs. L. T. Dean, W. Johnson, W. G. Pinching, C. M. Plumptre, V. Townrow, B. Wallis.

Dressers in the Throat Department.—Messrs. M. E. Ball, H. O. Brookhouse, A. H. Crook, S. J. Darke, R. A. Rankine, C. A. Wood.

Aural Surgeon's Dressers.—Messrs. M. E. Ball, H. R. Mullins, R. A. Rankine.

Post-Mortem Clerks.—Messrs. L. Bromley, W. H. Catto, C. H. Crump, P. C. Field, F. Kahlenberg, E. P. Poulton, V. T. P. Webster.

Medical Ward Clerks.—Messrs. F. S. Adams, H. G. Rice, T. D. M. Stout (Dr. Hale White); K. T. Khong, P. E. H. Patey (Dr. Pitt); J. G. Saner, D. C. Lloyd, H. Gardiner (Sir Cooper Perry); A. Neville Cox, J. W. Williams, H. W. Doll (Dr. Shaw). A. L. Gardner, R. Stout, H. G. B. Blackman, E. Billing, G. C. Lowe, E. P. Poulton, A. Stanley Roe.

Assistant Surgeons' Dressers.—Messrs. W. T. Chaning Pearce, H. F. Stephens, F. A. Dick, E. A. Penny, G. E. Warner Lacey, A. L. Saul (Mr. Steward); R. Montgomery, H. F. Renton, G. B. Cockrem, T. Lewis Jones, W. E. Levinson (Mr. Fagge); G. Maxted, W. H. Talfourd Jones, G. Dunderdale, W. E. Fox, J. Pryce-Davies (Mr. Rowlands); M. C. Thavara, T. T. O'Callaghan, M. M. Munden, C. E. Reckitt, A. D. Vazquez (Mr. Turner).

Surgical Ward Clerks.—Messrs. W. P. Vicary, G. T. Mullally, A. H. Todd, G. A. Blake, L. C. W. Cane, C. D. Killpack, M. C. Wall, H. H. Davis, G. L. Preston, O. E. Williams, F. B. Bull, H. L. James, H. W. Barber, A. M. Bodkin, J. H. Campain, A. C. Jepson, H. V. Leigh, B. Blackwood, J. M. Jarvie, H. T. Depree.

Change of Address.

Dr. M. Anslow-Alabone, from Lanark Mansions, Maida Vale, W., to 8, Porchester Square, W.

Captain Herbert O. M. Beadnell, R.A.M.C., from Hafod, Llandinam, Montgomeryshire, to Umballa, India.

Dr. R. A. Chisolm, from the Hospital for Children, Hackney Road, N.E., to 16, Weymouth Street, W. Telephone 3215 P.O. Hampstead.

Dr. R. G. Chase, from Guy's Hospital to "Sewardsley," 75, Saltergate Terrace, Chesterfield.

T. B. Layton, M.B., M.S., from the Poplar and Stepney Sick Asylum, Bromley-by-Bow, E., to Guy's Hospital.

Norris Snell, L.D.S., from 11, Museum Street, Ipswich, to 22, Museum Street, Ipswich.

C. F. Witcomb, L.D.S., from 51, Coombe Road, Croydon, to 96, Park Lane, Croydon.

Lectures* for Sessions 1908—1909.

WINTER SESSION. OCTOBER—MARCH.

†	LECTURERS.		DAYS.					
Anatomy (1st & 2nd)	Mr. Steward and Mr. Fagge	9	—	Tu	W	Th	—	—
Microscopical Pathology (3rd) ...	Dr. Boycott, Dr. Eyre, Dr. Nicholson, and Mr. Leeming	9	—	Tu	—	—	Fri	—
Pathological Classes (3rd & 4th)	Dr. Fawcett and Mr. Rowlands ...	9.15	—	—	W	Th	—	Sat
Bacteriology (Jan. to Mar.) (4th)	Dr. Eyre and Mr. Leeming	4	—	Tu	—	—	Fri	—
Practical Obstetrics (3rd & 4th)	Mr. Davies-Colley (Oct. and Jan.) ...	12	—	—	—	Th	—	—
Chemical Physiology (Jan.) (2nd)	Dr. Pembrey, Mr. Ryffel & Mr. Laidlaw	11	—	—	—	—	Fri	Sat
Chemistry (1st and pre. sci.) ...	Dr. Wade	12.15	—	Tu	—	Th	—	—
Practical Chemistry	Dr. Wade, Mr. Ball and Mr. Merriman	10-12	—	Tu	—	Th	—	—
Advanced Practical Physiology (3rd)	Dr. Pembrey, Mr. Ryffel & Mr. Laidlaw	11	M	—	W	—	—	—
Practical Medicine (3rd) ...	Dr. Cameron and Mr. Rippmann ...	12	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Dr. Fison	12	M	Tu (3)	—	—	—	—
Chemical Physics (1st)	Dr. Fison and Mr. Merriman	2	M	Tu	—	—	—	—
Practical Surgery (3rd)	Mr. Bankart and Mr. Layton	12.30	—	Tu	—	—	Fri	—
Physiology (2nd)	Dr. Pembrey (Oct.-Dec.)	10	M	—	W	—	—	Sat
Clinical Medicine (3rd & 4th) ...	The Physicians	4	—	—	—	Th	—	—
Surgery (3rd)	Mr. Symonds, Mr. Lane, Mr. Dunn and Sir Alfred Fripp.	9.30	M	—	W	—	—	—
Clinical Surgery (3rd & 4th) ...	The Surgeons	1.30	—	—	W	—	—	—
Elementary Biology (1st) ...	Mr. Assheton, Dr. Stevens, Mr. Youngman and Mr. Hughes.	10.30	—	—	W	Th(2)	Fri	—
Morbid Anatomy (3rd & 4th) ...	Dr. Fawcett, Dr. French and Dr. Hertz	2	M	Tu	W	Th	Fri	Sat(12)
Medicine (3rd)	Dr. Hale White, Dr. Pitt, Sir C. Perry, and Dr. Shaw.	4	—	—	W (3)	—	Fri	—
Ophthalmic Surgery (Jan.) (4th)	Mr. Eason	4	—	—	W	—	—	—
Public Health (Jan.) (4th) ...	Dr. King Brown	4	M	—	—	—	Fri	—
Anæsthetics	Mr. Rowell (Dec.)	—						
Dental Surgery and Pathology...	Mr. Wynne Rouw	4	—	—	—	Th	—	—
Metallurgy	Dr. Wade	4	M	—	—	—	—	—
Practical Dental Metallurgy ...	Mr. Hopson (Jan.)	2.30	—	Tu	—	—	—	—
Dental Anatomy & Physiology...	Mr. Maggs	4.30	—	—	W	—	—	—
Dental Mechanics	Mr. Lewin Payne (Oct.–Dec.)	4	—	Tu	—	—	—	—
Practical Dental Mechanics ...	Mr. Pillin (Jan.)	2.30	—	—	—	—	Fri	—

SUMMER SESSION. MAY—JULY.

†	LECTURERS.		DAYS.					
Medical Jurisprudence (3rd & 4th)	(Vacant)	10	—	—	W	—	Fri	—
Midwifery (3rd)	Dr. Horrocks and Mr. Targett	9	—	Tu	W	Th	Fri	—
Diseases of Women	Dr. Horrocks and Mr. Targett	9	—	—	—	—	Fri	—
Pathology (3rd)	Dr. Boycott	9	—	—	—	—	—	Sat
Mental Diseases (3rd)	Dr. Craig	9.30	M	—	—	—	—	—
Bacteriology (May & June) (4th)	Dr. Eyre and Mr. Leeming	4	—	Tu	—	—	Fri	—
Practical Obstetrics (3rd) ...	Mr. Davies-Colley	12	—	—	—	Th	—	—
Biology and Botany (pre. sci.) ...	Mr. Assheton, Dr. Stevens, Mr. Youngman and Mr. Hughes.	2	—	—	—	Th	—	—
Physiology (2nd)	Dr. Pembrey	9.30	M	—	W	—	—	Sat
Histology (1st)	Dr. Pembrey, Mr. Ryffel & Mr. Laidlaw	10.30	M	—	W	—	—	Sat
Practical Surgery (3rd)	Mr. Bankart and Mr. Layton	12.30	—	Tu	—	—	Fri	—
Practical Medicine (3rd) ...	Dr. Cameron and Mr. Rippmann ...	12	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Dr. Fison and Mr. Merriman	12	M	Tu (2)	—	—	—	—
Clinical Medicine (3rd & 4th) ...	The Assistant Physicians	1.30	—	—	W	—	—	—
Clinical Surgery (3rd & 4th) ...	The Assistant Surgeons	1.15	—	—	—	—	Fri	—
Morbid Anatomy (3rd & 4th) ...	Dr. Fawcett, Dr. French and Dr. Hertz	2	M	Tu	W	Th	Fri	Sat(12)
Materia Medica (2nd)	Dr. Beddard	4	M	Tu	—	—	Fri	—
Anæsthetics	Mr. Rowell (June)	—						
Operative Dental Surgery ...	Mr. Parfitt	2	—	Tu	—	—	—	—
Chemistry	Dr. Wade	9.30	—	Tu	—	Th	—	—
Practical Chemistry	Dr. Wade, Mr. Ball and Mr. Merriman	10.30	—	Tu	—	Th	—	—

* No effort has been made to include the many demonstrations or practical work.

† The numbers in this column refer to the years in which this course should be attended.

The Sciences.

Anatomy and the Dissecting Room.

How to begin Work.

A great many freshmen have already passed their preliminary examinations in Chemistry and Biology before they come up to Guy's. They are then ready to commence the study of two most important subjects—Anatomy and Physiology.

For the help of these new men, it is proposed to give such instructions as they may need in beginning the work of their first winter session at Guy's. It will be assumed that they have already decided what the general course of their study is to be; that is, briefly, whether they are going in for the Preliminary Scientific Examination of the London University or not. Information on these matters is readily obtained at the Medical School Office, and any student who is not clear in his mind as to the examination he has to prepare for, should read carefully pages 93–96 in "the Green Book."

Under the Five Years' Regulations of the Conjoint Board, the first object of the student (entering, for instance, in October, 1908) is to pass the examinations in Chemistry and Biology, as failure to complete these by the following March (*i.e.*, 1909) must postpone the date at which the Second Conjoint should be passed (*i.e.*, April, 1910), *vide* par. 6, p. 377, so that students are advised, unless they have passed either one or both of the above subjects before entering the hospital, or are unusually well versed in the subjects for these examinations, to postpone dissecting until one or both (Chemistry and Biology) have been completed.

What follows refers, therefore, only to those who intend to undertake their dissections at once.

Thursday, October 1st.—There is no actual work done on this day, but each student who is ready to dissect (*vide supra*) should pay his fee for anatomical material in the Medical School Office, and then interview the Senior Demonstrator in the dissecting-room and see that his name is put down for a "part." He should then study the Red Book—which contains the rules of the dissecting-room—and purchase the necessary instruments and the other paraphernalia therein indicated. Any spare time is well spent in learning where the museums, class-rooms, and theatres are situated. The ground plan at the front of the "Green Book" will show them at a glance, and serve as a very efficient guide.

Friday, October 2nd.—At 9 o'clock in the morning the start is made, and we get our first introduction to the duties of hospital life at a lecture by Mr. Steward in the anatomical theatre, and at 12 o'clock a demonstration is given to all first year's men by the Senior Demonstrator (Mr. Thompson) in the small theatre attached to the dissecting-room, when the way to work in the dissecting-room is fully explained.

To find a "Part."

Look down the list of names on white cards which are suspended upon the wall of the dissecting-room opposite each subject or body. Be careful to take the proper side (right or left) which is allotted to you. If you fail to find your name on these cards, make yourself known and report the fact to one of the demonstrators present. The next thing is to obtain a bandage and cloth from the attendant (Hancock), who will be found in a room outside the dissecting-room. With these the "part" must be covered up at once to prevent the skin from drying. If the "part" is a limb, bandage it firmly from the hand or foot upwards as far as the bandage will go, and cover the remainder with a cloth, *but be careful to leave the metal ticket exposed to view. This ticket must on no account be removed.*

The Requisites for Dissection.

The following articles are essential, and must be purchased at once:—

a. Case of instruments. This should contain two or three good knives (preferably all-metal), two pairs of large forceps with a weak spring, one pair of strong pointed scissors, hooks, needle and blowpipe, and can be obtained from Hancock, the dissecting-room attendant, or at Messrs. Down Bros., of St. Thomas's Street; Messrs. Arnold & Sons, West Smithfield; Messrs. Maw, Son & Sons, Aldersgate Street; or Messrs. Allen & Hanbury, Plough Court, Lombard Street. Price about 15s. to 20s. Small or delicate instruments should, as a rule, not be procured.

b. Books. These are obtainable at Grattan's in the Borough High Street, next door to the post office. It is advisable to obtain *Cunningham's Practical Anatomy* (2 vols. 10s. 6d. each) for use in the dissecting-room, which show how to proceed and what is met with in the course of dissection; *and* one at least of the standard text-books, viz., Gray, Cunningham, Morris, or Quain's Text Book. The inquirer will hear their merits compared at the introductory lecture and demonstration; if still in doubt he should consult personally one of the demonstrators, and take with him any old text-book he may possess for inspection and advice as to its use.

c. An apron and sleeves for the sake of protection and cleanliness. These are sold by Hancock. Any old coat may be worn under them. Instruments, books, apron and coat must be safely put away in a locker provided for the purpose; the key is obtained by making a deposit of 5s. at the Medical School Office. During the day hats and coats are kept at a special cloak-room under the Wills Library.

d. A disarticulated skull and a half skeleton. (*See below.*)

With regard to all the necessary articles mentioned above in a, b *and* d, *it is well to point out to new students that many men who have just completed their anatomical studies may wish to dispose of some of the above articles second-hand, and new students may obtain information about, and details of such things, to be bought from the Librarian or Hancock, with whom such things are usually lodged.* Before completing any such purchase it is always best to make sure that the books are of the last edition

published and that the instruments are reliable, points on which any of the demonstrators will gladly give advice.

How to Dissect.

The instructions given on this point in the text-books are by no means clear to anyone who is working in the dissecting room for the first time. He finds quite a new language in use, and no explanation of it in the margin. Thus, he is told to "make an incision," instead of "cut"; to "reflect the integument," for "turn back the skin"; "anterior and posterior," instead of "in front and behind." Not a little of the difficulty and dulness attaching to anatomical description depends on the need of a mental translation of the language in which they are written.

To deal fully with the skilful act of dissection is unnecessary here, and we will merely give such short directions as are needful for the work of the first two or three days. The objects of dissection are—firstly, to educate the sense of touch, and to teach the hand and the eye to work together in delicate manipulation; and secondly, to enable the student to see and handle the different structures that he reads about in his books. The following advice may be given:—

1. Take your book (Cunningham) by which you intend to dissect and read over the pages giving directions for the skin incisions to be made in that particular part you are about to dissect.

2. Cut through the skin along the lines given in the books.

3. Turn back *the skin only*, leaving the fat upon the body. This is done by holding the knife obliquely with its edge towards the skin.

4. Take away the fat carefully without damaging the dense white layer which covers the muscles.

5. Clean the surface of the muscle. To do this make the muscle taut by moving the limb, or pulling on it with hooks; then with the point of the knife clear away everything covering the muscle by working *with* its grain or fibre, *not* across the fibres.

6. Before taking any fresh step in your own dissection get a notion of the arrangement of the parts you are going to expose, either from another man's part, or from the "pickle-room," or wax model museum preparations. *Most important of all, never remove any structure until you have obtained a good mental picture of it, and have also read in your book the description of it, and have satisfied yourself you know it.*

7. Work very slowly at first. To turn back the skin carefully is quite enough to occupy the first day's work-time.

8. Cover the "part" up with a cloth before leaving it for the night.

The student should, on the first day, ask one of the Demonstrators for a copy of the Red Book, which contains the rules of the dissecting-room, and also much useful information as to classes which must be attended, and particulars of the School examinations.

The first year's man will find that he has first of all to dissect an arm or a leg. Having found his part, he should next examine the notice board, where he will find particulars of the bone classes which are held twice a week by Mr. Mollison and Mr. Hughes. He must attend the classes on the part he is dissecting, and at these he will find the anatomy of the bones and muscles he is dissecting fully explained.

Osteology.

A thorough knowledge of the bones is the basis of anatomy, and hence the subject cannot be too carefully studied. The student will find that to know his bones well is of importance, not only in the School Elementary Anatomy Examination, but also for the Second Conjoint, Intermediate M.B., Primary F.R.C.S., and even for the Final Examination in Surgery.

Like other branches of anatomy, it must be learned practically—by handling the bone, reading the description of it, and noting the various marks upon it, each one of which has its meaning. In order that the bones may be studied at home as well as at the hospital, it is very important that each student should possess them. Half sets of bones, that is, the skeleton of one side of the body with the spine and head, can be obtained second-hand at a very moderate outlay, and if carefully used they will at the end of the course readily fetch half the original cost, or even more. Some very useful half-sets (second hand) are to be seen at Messrs. Millikin & Lawley's, 165, Strand, W.C., price 30s. If these are disposed of at the end of the Second Conjoint Examination for half the price, it follows that the immense advantage of having the bones always at hand while preparing for the examinations is obtainable at the expense of a few shillings.

In selecting a half-set of osteology it is as well to have some advice, which will be readily given by one of the demonstrators. See that the half-set is complete, and that each bone is of the *same* side. Avoid "the nice white bones," which dealers always charge extra for, and choose the rougher, better marked and dirtier ones. The preparation which makes them white does away with many of the marks and ridges which have to be studied. With regard to the disarticulated skulls, try the separate bones and see whether they fit into each other properly, as it is not uncommon to find skulls offered for sale, the bones of which have come from different subjects, and hence cannot be articulated.

It may be necessary to caution men against neglecting the subject during their first year: they will find the second year's work quite heavy enough as it is, and moreover may suffer the mortification of being spun in the school elementary anatomy examination at the end of the first winter session, if they neglect the bones in their first term's work.

Dental Students.

A dental student, on entry, must pay the fee (10s. 6d.) for material at the Medical School Office, on October 2nd, between 10 a.m. and 1 p.m., so that a part may be allotted to him at the earliest opportunity. He should obtain a copy of the rules of the dissecting-room, and study those paragraphs which specially concern him.

He should be careful not to miss the demonstration given by Mr. Thompson to first year's students, on Thursday, October 1st, at 12 noon.

It is very important for first year's dental students to commence their anatomical studies without delay. During their first six months they should dissect the upper and lower extremities, and attend the bone classes held by Mr. Mollison and Mr. Hughes throughout the winter and summer sessions. They should pass the elementary anatomy examination at the end of their first six months if possible, or failing this, not later than nine months from their entry at the hospital. The subjects of this examination are :—

1. All the bones and ligaments.
2. The muscles and fasciæ of the upper and lower extremities.

The importance of having a thorough knowledge of the bones of the head and spine, with the muscles attached, cannot be overestimated. Lack of such knowledge has caused the downfall of many at the final L.D.S. examination.

Having passed the elementary anatomy examination, dental students are allotted a head and neck, in which they are expected to dissect, besides the muscles and ligaments, the vessels, nerves, and other soft parts, and also to acquaint themselves with the anatomy of all the special regions of this part, *e.g.*, the orbit, mouth, pharynx, etc.

Mr. Mollison holds special classes for these students, throughout the winter session, in the dissecting-room theatre, once a week, and a test examination is held on the work at the completion of the dissection and the course of demonstrations. It will be agreed that the second dissection is even more important than the first, and it is well to realise that, as the work done by each man is noted and marked every week by Mr. Mollison, and men are only signed up for the necessary session's work when these marks are satisfactory, careful and conscientious dissection, punctual attendance at demonstrations, and industrious reading up of all the work, must be begun as soon as the dental student enters the dissecting-room, and continued until the subject is mastered.

It is very essential that the study of anatomy, physiology, and surgery should be prosecuted energetically from the outset, thus obviating the necessity for "cramming" these subjects when preparing for the Final L.D.S. examination. Careful and patient dissection is the easiest way to learn Anatomy. An attempt to "cram" it from books is certain to result in disaster.

PHYSIOLOGY.

Physiology, which treats of the working of the healthy body, and forms, therefore, the institutes of medicine and the necessary foundation of any rational mode of treatment of the body in disease, differs from its sister subject, Anatomy, in that it requires much greater intellectual efforts for its acquisition, and a more thorough preliminary training for the comprehension of its doctrines. Physiology consists chiefly in the application of the natural laws elicited by the researches of physicists, chemists and biologists to the explanation and description of the phenomena occurring in the living body, so that an acquaintance with the chief laws of physics, chemistry and biology forms the necessary basis for the study of physiology. The study of the nervous system, moreover, requires some knowledge of psychology. The difficulty and importance of the subject would seem to indicate, in the clearest possible manner, the necessity of pursuing its study throughout the short space of two years which are devoted to the subjects that are preliminary to the work in the wards. On this account, the student beginning his medical studies in October must give all his energies to getting up his biology in order to pass in it at the earliest possible opportunity, and he may profitably combine with the biology lectures and classes the reading of some physiology, such as Huxley's *Elementary Lessons in Physiology*, or the smaller works on the same subject by B. Moore and by Foster and Shore. He is advised to attend the physiology lectures at this time, but cannot be "signed up" for them.

By the ordinary student the practical study of the subject included under the heading "Physiology" is begun in the first summer session. During the whole of this session he must attend the classes in Practical Histology. These are held in the students' histological class-room three times a week; each class lasts two hours. Students attending this course must provide themselves with a compound microscope, certain mounting materials (a list of which can be obtained at the office), and with Schäfer's *Essentials of Histology*, which should be carefully studied in the intervals between the classes.

At the end of the summer session an examination is held in histology. All students who have attended this class must enter for the examination. Only those who pass the examination will be allowed to attend the tutorial classes in physiology held during the second winter session in preparation for the examinations of the Conjoint Board. Those who fail at this examination will be examined in the following session.

During the first summer session and the first half of the second winter session, the student should attend regularly the lectures on physiology held three times a week, on Mondays, Wednesdays, and Saturdays. During the same time those who have passed the histology examination at the end of the previous session should attend the tutorial classes held by one of the demonstrators throughout the session. At the same time he should read up the subjects in some text-book such as Starling's *Elements of Human Physiology*, or Halliburton's *Handbook of Physiology*.

During the winter session, *i.e.*, from January to March, students must attend the classes in practical physiology, which are held on Friday and Saturday mornings from 11 to 1. From October to Christmas physiological chemistry is worked at in the room devoted to that subject. While attending this class, they are recommended to read up the subject in *Practical Physiology* (published by Arnold) which is used in the practical work.

From January to March the class is held in the histological Laboratory, where the student becomes practically acquainted with physiological apparatus, and performs simple experiments.

Students who have been diligent in following this course of studies will be ready to enter for the second Conjoint examination at the end of this session. Shortly before this examination, a test examination is held by the demonstrators in order to judge of the fitness of the candidates. Those who fail to pass the Second Conjoint at this time must attend the revision classes held by the demonstrators during the two or three months preceding the July and January examinations of the Conjoint Board.

Certain modifications in this course of studies is necessary for those who are going up for the M.B. of London or other Universities. Having passed their preliminary scientific before entering, they are free from the study of biology during their first winter session. They should therefore attend the physiological lectures during this session, at the same time studying the subject in Starling's *Physiology*. In their first summer they attend the histology classes, and read Schäfer's *Essentials of Histology*. During their second winter, they should attend the class in advanced practical physiology, which is held twice a week, each lesson occupying between two and three hours. During this session they are recommended to read up the subject in Stewart's *Manual of Physiology* and use *Practical Physiology* in the advanced practical work. This class should also be attended by candidates for the first F.R.C.S. examination, although in their case attendance may often be profitably postponed until the third winter session. The reading for this examination is similar to that required for the Intermediate M.B. of London.

Those who are desirous of obtaining distinction at the Intermediate M.B. should supplement the course of reading already indicated with original papers in the *Journal of Physiology* and with parts of Schäfer's *Text-book of Physiology* and *Recent Advances in Physiology and Biochemistry*, edited by L. Hill, and Leathes' *Problems in Animal Metabolism*. Such students will also find parts of Foster's *Physiology* extremely useful and suggestive. University students should also attend the advanced lectures given on Physiology for the London University.

Revision classes are held by the demonstrators during the two months preceding the first F.R.C.S. and first M.B. examinations for the special preparation of candidates for these examinations.

List of books recommended:—

FOR COLLEGE MEN.—Schäfer's Essentials of Histology; Starling's Elements of Human Physiology, or Halliburton's Handbook of Physiology; Practical Physiology, published by Arnold.

FOR UNIVERSITY MEN.—Stewart's Manual of Human Physiology; Embryological parts of Quain's Anatomy; Howell's Text-book of Physiology.

BIOLOGY.

The course of instruction for the Preliminary Scientific of the London University M.B. examination consists of lectures which are given on Wednesday and Friday at 10.30 a.m., and on Thursday at 2 p.m., and of demonstrations and practical work on Wednesday and Friday mornings 11.30 to 1.30, and on Wednesday afternoons 2 to 4 p.m. The course of lectures naturally includes all the types required for the Preliminary Scientific (M.B. London) Examination, and a printed syllabus of these lectures is given out at the beginning of the session. The Biological Laboratory is open at all times between 8.30 a.m. and 5 p.m., so that students may revise their work and complete any part they may have been unable to finish in the regular hours. Those students who are preparing for the Biology examination of the Conjoint Board of the Royal College of Surgeons and Royal College of Physicians will attend certain of the above-mentioned lectures, which are specially noted in the above-mentioned syllabus. The practical work for Conjoint Board students is nominally carried out on Wednesday and Friday mornings, but it is always open for these students to attend on Wednesday afternoons if occasion demands. The practical class is held immediately after lecture in the Biological Laboratory. The requisite instruments, books, etc., for this course should not be purchased until after consultation with the lecturer, who will advise as to these in the first lecture. It is especially recommended that the purchase of a microscope should be postponed until after consultation with the lecturer, because a microscope has to serve throughout a student's career, and indeed afterwards as well, and it is important that an efficient instrument should be acquired in the first instance.

The first lecture will be given on Friday, October 2nd, at 10.30 a.m. T. G. S

CHEMISTRY AND PHYSICS.

The student is sometimes tempted to regard Chemistry and Physics as mere preliminary studies, of little importance when once the respective examinations have been passed; and, unfortunately, he will find no lack of encouragement in this idea from those who, from lack of ability, or more often from lack of industry, have found these subjects irksome. But when it is reflected that vital activity is dependent on the incessant balancing of chemical changes of the most complex description, it cannot fail to be recognised how futile it is to attempt to understand the working of the human body, the greatest of living organisms, without a firm grasp of primary chemical and physical processes. Scarcely a step, indeed, can be taken in Physiology, Pharmacology, or Pathology without reference to chemical facts and methods; and, in addition to these practical applications, the exact habits of work and thought acquired in the chemical and physical laboratories are simply invaluable later in enabling the student to find his way through the morasses of ill-digested observation with which he will often be confronted.

The above principles are now for the first time fully recognised in the new curriculum which has just been issued by the University of London, and should be carefully studied by every London student. This curriculum has been framed with the utmost care, with the object of leading students to their life work by the shortest and most direct route: first, through the pure sciences, carefully adapted to their future applications; next, through the applied sciences, and finally to clinical method. The matriculated student will, in his first year, study Inorganic Chemistry, Physics, and General Biology, and at the end of this period, provided he has worked diligently in the laboratories, and attended the lectures and revision classes regularly, should have no difficulty in passing the First Examination for Medical Degrees. In his second year he will study Organic and Applied Chemistry, together with Anatomy and Physiology, and at the end of this period, provided, as before, that he has worked steadily from the commencement, should have little difficulty in passing the First Part of the Second Examination for Medical Degrees. Anatomy, Physiology, and Pharmacology are then taken as the Second Part of this Examination, at the close of the third year, prior to commencing clinical work in the wards.

From the Conjoint and the Dental student only six months' work is required. but those entering without previous knowledge of Chemistry and Physics will find that time hardly sufficient, and are usually advised to take the full "year" of three terms, or nine months.

But, whatever the ultimate aim of the student, his success at the examinations will depend very largely on the care and thoroughness with which he has done his laboratory work. Neither books nor lectures are in themselves enough; their use is to direct the student and help him to arrange and digest his knowledge. The more first-hand knowledge he acquires for himself in the laboratory, the more benefit he will acquire from reading, lectures, and revision classes. The last, indeed, as their name implies, presuppose that the student has acquired a working knowledge of his subject, and are intended more to assist in the arrangement of ideas and clearing up of difficulties than in the acquisition of fresh knowledge. Guy's men have no excuse for neglecting laboratory work. The Chemical Laboratory, for example, is open every day from 9.30 a.m. to 5 p.m., and students are strongly urged to form early the habit of spending their spare hours, apart from those officially allotted, in one or other of the laboratories. Reading should be left for the evening. After a day in the laboratory, reading a good text-book will be found to give ample scope for thought, and rarely, indeed, be tedious. It is reading without practical experience that is so destructive of thought, and such reading is very properly stigmatised as "cram." "Cramming," or the memorising of words and phrases, without a knowledge of the corresponding realities, is one of the worst intellectual habits a student can acquire, and in the long run invariably leads to failure.

For the coming term, Chemistry Lectures start on Thursday, October 1st, at 12.15 p.m. (Chemical Theatre); but before this students should go to the Chemica Laboratory (10 a.m.), to receive their lockers and commence practical work. Practical Organic and Applied Chemistry starts on Thursday, October 1st, at 2 p.m., and the Lectures on Friday, October 2nd, at 1 p.m. Physics Lectures commence on Friday, October 2nd, at 2 p.m. (Physical Theatre).

PRACTICAL PHARMACY, MATERIA MEDICA, AND DISPENSING.

One of the many important things all medical students must know is how to write a prescription; it may even be necessary for the majority, when qualified, to know how to dispense the same, so that the student will do well not to neglect acquiring as much knowledge of this subject as he can.

The principles underlying the art of prescribing are comparatively few and are quite easy to grasp, especially to the man who remembers his chemistry, and has, in addition, some general idea of the chief physical properties of the substances commonly used in medicine. In addition, a considerable amount of purely memory work and application is required in studying the doses and preparations of the drugs in use.

The student is taught practically the methods of prescribing, he practises writing prescriptions for combinations of drugs with due regard to incompatibility, and he is taught how to dispense the prescriptions he has himself written.

The course covers the syllabus of the Practical Pharmacy of the Conjoint, the Intermediate M.B. Lond., and the Third M.B. Cantab.

During the year there may be three courses of three months each, should a sufficient number of students require instruction, which is given in the practical pharmacy class at the Dispensary by Mr. Finnemore, B.Sc. Lond., F.I.C., the Hospital Pharmacist.

THE MEDICAL WARDS.

Work in the medical wards is taken in two sections of three months each, with an interval of three months, during which time the post of assistant surgeon's dresser is held, together with that of assistant physician's clerk.

A few words of advice to the oncoming medical ward clerk may not be out of place. In the first place we would urge him most strongly *not* to take his "manual of medicine" and read it through from cover to cover. He should, however, endeavour to become thoroughly acquainted with those diseases which he finds examples of in the beds which have been allotted to him.

Secondly, he must become familiar with the various physical signs indicative of disease in the various organs of the body, comparing his own cases with others which he finds in the wards. Too often the keen and energetic clerk is so busily engaged in noting and learning signs of disease that he neglects to observe and remember appearances and landmarks which may be, or are, compatible with perfect health. We would advise him,

therefore, to listen to the "normal" heart as well as to the "failing" heart, to become accustomed to the normal vesicular murmur before he begins to grapple with the mysteries of "bronchial breathing."

Thirdly, we would strongly advise him to make a friend of his particular house-physician, from whom he will obtain many "tips" and "wrinkles" which will prove of immense value to him for all time, smoothing over rough places in the stony ways of medicine, and clearing up abstruse questions which have arisen as a result of his reading.

From his house-physician, also, the medical ward clerk will learn when a "tapping" will take place, when an urgent venesection will be required, or of the necessity for the surgeon's knife. In fact, if he be only willing and energetic, he will find the house-physician a complete "medicine-book" as well as a most kindly friend.

The arrangement for work in the medical wards is as follows:—The registrars are two in number; one is attached to the beds of Dr. Hale White and Dr. Shaw, the other to the beds of Dr. Pitt and Sir Cooper Perry. Each registrar makes a formal round four times in the week, and on the other two mornings he may be found in the clinical laboratory, or assisting at the more lengthy examinations in the wards. When the registrar visits any bed, the medical ward clerk responsible for the report of that bed MUST be present with rough notes of the history of the case, and he should, if possible, be able to describe the physical signs of disease. These rough notes, in the compiling of which the clerk should obtain the help of the clinical assistant, should subsequently be neatly copied into the report sheet, in order that the physician may inspect them upon his visit to the wards in the afternoon. After the visit of the physician, the ward clerk should at once enter the remarks made by the physician, and also the diagnosis, if the latter has been made. Only the physician's diagnosis is to be entered in the report.

The registrars begin their morning round at a quarter-past ten; no lengthy examinations are made after a quarter-past twelve, in order that dinners may be served. The wards, however, are open to the ward clerks until one o'clock, when they are closed for nursing purposes until half-past one. We mention this point because of late there has been some misunderstanding. The boards which are sometimes hung upon the doors of the wards at mid-day, indicate that the wards are closed to visitors.

In compiling his report, the ward clerk should be brief and thorough; he should avoid being "long-winded." He should pay attention to "family history," which may indicate a predisposition to disease, and he should make a careful summary of the previous illnesses from which the patient has suffered, consulting, if necessary, the records which are kept in the medical registrar's room.

Whenever possible, he should attend the post-mortem examinations which are held daily, and he should *always* be present at the autopsy of any case the record of which he has been keeping. The abstract of such autopsy is subsequently to be obtained from the post-mortem room and copied into the medical report.

With regard to books, we would recommend him to obtain Taylor's "Practice of Medicine," and "Clinical Methods," Hutchinson and Rainy. Later on, during his second term of office, Osler and Allchin may claim his attention.

PATHOLOGY.

As soon as a student has passed his Second Conjoint or Intermediate M.B. examination, he should begin his study of pathology. Without a sound knowledge of this science it will be impossible for him to acquire any useful knowledge of either medicine or surgery. It is only by following out his cases to the bitter end when he is a medical ward-clerk, that he will see the anatomical changes produced by the diseases of which he has been learning the symptoms and the treatment in the wards. He will also begin to understand the snares and pitfalls that beset the path of the physician, and will often come back from the post-mortem room a sadder and a wiser man. He can, therefore, never be too emphatically urged to attend the autopsies on every one of his cases, and to spend as much time as possible in the post-mortem room. Autopsies are conducted every day of the week at 2 p.m. (Saturdays at noon), by Dr. Fawcett and Dr. French, whose custom it is to draw the attention of the student to any changes that may be found. Again, a sound knowledge of surgical pathology will lighten the student's labours during his time in the surgical wards. It may well be said that no man can be a surgeon unless he is a good pathologist. He is expected to know the various forms of new growth and the relative frequency with which they occur, and the rapidity of their course in the different organs of the body. Having arrived at this diagnosis, he can remove the tumour and subject it to a microscopical examination, when his joy will be great at the accuracy of his diagnosis.

In order, then, to gain a useful knowledge of the naked-eye appearance of pathological conditions, he should spend as much time as possible in the post-mortem room, and also examine the excellent collection which is kept in the museum. Here the result of the autopsies and operations of many years are presented to him, but he should bear in mind that going round the museum cannot in any way replace the study of the fresh organs in the post-mortem room. He should also attend Dr. Fawcett's class on medical pathology and Mr. Rowlands' surgical pathology, which is held three times a week during the winter session. These classes consist of demonstrations on the naked-eye appearances of diseased organs, and are illustrated by specimens from the museum and the post-mortem room. They are held in the morning, and only last half an hour, so as to clash as little as possible with clinical work.

Equally important is a knowledge of microscopical pathology, where he will learn the essential nature of pathological changes. A class on this subject is given by Dr. Boycott and Dr. Eyre on Wednesday afternoons

and Thursday mornings throughout the year. Bacteriology is taken in October to December and April to June, and morbid histology from January to March and July to September. The class must be attended during surgical ward clerking or the first three months of medical ward clerking, in order that he may acquire a good groundwork which he will be able to enlarge upon as he goes along.

In order to learn something of the principles which underlie pathology, the student should attend the lectures on general pathology. In May and October there are also short courses adapted for the requirements of candidates for the first part of the Third M.B. Cantab., and the final M.B. of Oxford and London Universities.

There is no text-book that covers the whole field of pathology. New discoveries are continually being made. Attendance on a course of lectures and demonstrations, in which the newest work is taught the student, will therefore be much more valuable to him than the perusal of any book. Should he wish to supplement his knowledge, he can do so by reading many of the articles in Allbutt's "System of Medicine," first and foremost among which is Adami's Treatise on Inflammation. He will also gain much help from Hewlett's, Green's and Lazarus Barlow's Manuals. Muir and Ritchie's text-book on Bacteriology should be read by those who are attending Dr. Eyre's course. Strangeway's Practical Morbid Anatomy will be found useful to acquire technique, especially by Cambridge men, as they are allowed to bring it into the practical part of the first part of the Third M.B.

BACTERIOLOGY.

The compulsory course in Bacteriology forms part of that in Microscopical Pathology, is held during the months of October, November, and December, and is repeated in April, May, and June. The course comprises short demonstrations, with especial reference to the life-history of the bacteria pathogenic to man, followed by practical instruction in the rudiments of bacteriology as applied to medical diagnosis. To this end the members of the class study the methods of staining sputum, pus, and exudates to demonstrate bacteria; the methods of collecting morbid products for bacteriological investigation, and the estimation of such antibodies as agglutinins, opsonins, etc., in the body fluids; in fact, the technique pertaining to all the various examinations which can be undertaken in connection with the ward work. In addition, students are instructed in the practical details of media making, culture and staining methods, and they individually examine the more common pathogenic and non-pathogenic bacteria.

Consequently, Bacteriology should be regarded not as a compulsory subject of merely scientific interest, but as one which has an important and ever-present bearing upon diagnosis, and upon treatment. This course should therefore be taken as early as possible during the period of clinical study, if possible, when no ward appointments are being held.

Lectures on the bacteriology of special organs, and the recent development of bacteriological therapeutics (serum and vaccine treatments) and diagnosis, together with the various theories of immunity, etc., upon which these methods are based, are given weekly during January, February, and March.

THE SURGICAL WARDS.

In the surgical wards there is a division of labour, and corresponding to this division, the appointments fall into two classes—clerking and dressing. The student's first introduction to clinical work is as clerk in the surgical wards, and it is not unlikely that he may, on his first entry, be a trifle discouraged. The reasons for this are obvious. Entirely ignorant of surgery and even of the terms in common use, he is at once required to write full accounts of the cases admitted to the wards. He will find, however, that by paying attention to the advice we give him, his difficulties will be found to be *anything but insurmountable*.

Being the junior appointment in the hospital, there is a tendency in the minds of some, and a little more than a tendency in the minds of others, to belittle the post. That is unjust, and is the result of ignorance of the real functions of the surgical clerk. What the medical clerk is to the medical side, the surgical clerk is to the surgical side. The post is junior in point of time, but does not necessarily carry with it any stigma of inferiority. Their duties are identical: the preparation of the permanent hospital records of the cases admitted to the wards. What difference there is consists in this: the machinery of the medical side is less complicated than that on the surgical; whereas the whole of the work in the medical ward falls on the clerk, in the surgical wards it has been found advisable to specialise and to separate—for the sake of greater proficiency—the duties of clerking and dressing. This separation has thoroughly been justified by the results, the chief difficulty being the dependency of the clerk on the dresser for many details of importance. Dressers should, therefore, remember that from them the hospital expects such assistance as will render the reports as complete as they can be made. On the clerk, however, rests the responsibility, and the excellence of his reports is a sure indication of smooth working and mutual assistance in the firm to which he belongs.

The most important point for a clerk to remember is that in after years cases and not book work will form his mainstay in practice, and that he cannot too soon get the clinical entity and results of treatment into his memory.

The appointment of an overseer to each firm of clerks in the person of a clinical assistant in the surgical wards is of inestimable value, primarily to the clerks, secondarily to the whole firm. The clinical assistant should be the immediate "ear" of all his clerks, to instruct them in their duties in the wards, also relieving the surgical registrar of many details in the filling in omissions of the reports of his firm.

We do not wish to exalt the clerk unduly, but to insist merely that in his work the same care and attention to detail, the same knowledge of surgery and human nature, are as necessary as in other appointments. Let him bear in mind that to him is given by the hospital the task of keeping its records. These are bound and kept, and by his work thus perpetually in evidence a man is judged. Bad reports are a lasting disgrace; good reports a lasting honour. The importance of good careful work by the clerks cannot be over-estimated. In the nature of things it cannot be perfect, but it must be as perfect as he can make it. By his first work in the wards he will be judged, and he will find that it is very hard to live down a bad clerkship. At the same time that he bears in mind the difficulties and responsibilities of his post, he should remember that he is a junior, and that any assistance he can lend his seniors should be offered ungrudgingly, and in return for this he will undoubtedly meet with that consolation and help in his work which is so necessary. There is no loss of dignity sustained in carrying screens to patients, or in the thousand and one small opportunities which present themselves of helping the other workers in the wards.

To the dressers we would submit that the performance of dressing is no part of the clerk's duty, and that it is no kindness to him to request him to undertake what he cannot from his position with good grace refuse, and what nevertheless he is unfitted to do.

The work of the firm, as a whole, should be the interest of each individual member of it. Pride should be taken not only in its splinting and dressing, but also in its reporting. A good house-surgeon and a good dresser will see that the reports are not below the level of those of other firms, for as they represent the work of the firm the individual members should see that they give a fair and accurate idea of that work. The clerk, aided by the clinical assistant, from this point of view is to be regarded as the mouthpiece of the firm to succeeding generations. The firm should see that he represents it fairly. It is essential that either the clerk should live within walking-home distance of the hospital, or else get a room for the take-in week. All really good casualty work is done at night, and the periods for seeing the actual Crofting and treatment of fractures is all too short as it is.

As soon as he is appointed, he should find out from the surgical registrar to whom he is appointed. A few days before taking over the work he should learn from his predecessor what he can about the cases he is to take charge of, so that the work may be continued as nearly as possible without a break. At the present time there is an entire change of clerks every three months, but in the way indicated above, the break in the work may be obviated to some extent. He should learn quickly to take accurate temperatures, and pulse and respiration rates, and test urine, for without any exception the temperature, pulse and respiration rates, and condition of the urine must be included in the notes of every case on admission. The surgical registrar sees every new case with the clerk on the morning after admission, when he expects a history of every case to be ready. This, if vague, is useless. All symptoms should be set down in exact order, with the dates of their appearance. The exactness in detail is of the highest importance, and is a measure of the care with which the clerk has done his work. He should have a note-book, and should put down in it everything about the case that he can obtain from the surgeon, house-surgeon, clinical assistant, and dresser. This should be copied into the report as soon as possible. We would impress upon each clerk the value of seeing everything done by the dressers or house-surgeons—the operations, putting up fractures, especially when done at night in take-in week, and this should apply to manipulations on every case under the surgeon, and not only to the cases which the individual clerk has to report—as much may be learnt in this way which otherwise can only later be gathered with much greater effort.

He should also attend the practical surgery classes of the surgical registrar, who gives four courses a year, each beginning on the appointment of the new surgical ward clerks, and especially designed for their instruction in all matters relating to that appointment.

Lists of the duties appertaining to each appointment are supplied to the students, and these are to be carefully followed out. The hospital not only expects this, but insists on it. We have laid stress so far on the appointment of surgical ward clerk, as it is the first post that the student holds, and because he is so often quite unaware of the objects of the appointment.

He will in time become a dresser, and will by that time have learnt the traditions that underlie his office. He should, before accepting office, have acquired most thoroughly the principles of aseptic surgery, and, on no account, ever depart from them subsequently. Let soap and water be his sheet anchor.

The surgical wards are visited every day by the surgeons and assistant surgeons at 1.45. Notice of operations, which usually take place on Mondays, Tuesdays, Thursdays and Saturdays, except for emergencies, is posted overnight in the colonnade by the House-Surgeon for the week. The surgeons are assisted at the operations by the dressers, and no others should stand about the well of the theatre, the only exception being the particular ward clerk to the case.

Although we believe there is no rule which prevents freshmen attending operations and clinical demonstrations, we would point out that such a course of action is useless to them, and is not encouraged by the authorities.

Finally, we should like to repeat that although specialization has provided a clerk responsible for the drawing up of the hospital records, yet as this report is an account of the work performed by the firm as a whole, it touches the honour of every one in it that the report should be an accurate statement of the work done. The firm should be considered the entity, each separate member of which fulfils his own function, each at the same time being dependent on the others for the smooth, even working of the whole.

ANÆSTHETICS.

One of the most important of the appointments for senior students is that of Clerk to an Anæsthetist. The appointment is best held after that of full dresser, but it may sometimes be done concurrently with the latter appointment, provided that the day the anæsthetist attends does not clash with the days of attendance of the surgeon to whose firm the dresser belongs. The appointment, which is for one month, is now compulsory; that is, every man must have held it before he can present himself for his final examinations. In future, candidates for House Appointments will be required to attend a second course of instruction under one of the Honorary Anæsthetists, and to possess a certificate of proficiency. During his month of office the clerk attends one afternoon a week in the operating-rooms, either surgical or gynæcological, or at out-patients' when he administers anæsthetics under the supervision of the anæsthetist. He thus becomes acquainted with the various forms of apparatus, and gains practical experience in the administration of chloroform, ether, and A C E mixture. He also attends one morning a week at 9 a.m. in the dental department, where he has ample opportunities of learning how to give nitrous oxide, nitrous oxide and oxygen, and ethyl chloride for dental operations. Before holding the appointment the student should attend Mr. Rowell's course of lectures on anæsthetics, for though this is essentially a practical subject, it is very necessary to know something of the action of anæsthetics and the symptoms occurring during anæsthesia, and also to know what dangerous symptoms to look out for, and the treatment that should be adopted. When making application for the appointment, the clerk may be in doubt as to whether to apply for the out-patient department or for the theatre. Each has certain advantages. The clerk will probably give more anæsthetics at out-patients', but those given in the theatres are usually of much longer duration, and useful experience is gained in keeping patients for some time in the stage of anæsthesia requisite for a prolonged operation. Hence there is but little to choose between the two.

The clerk should endeavour to watch the patient himself, and form his own opinion of the condition of the patient, and not be a mere machine for holding a mask at the direction of the anæsthetist. He should be careful to consider the feelings of the patient, especially when he is dealing with a nervous individual. Suddenly to place a charged A C E cone over a patient's face without a word of warning is to court difficulties, and even dangers, in the administration. He should remember that "burned faces," sore eyes, sore tongues, split lips and broken teeth are a reproach to an anæsthetist, and that if these accidents occur with private patients his reputation as an anæsthetist will be seriously damaged.

Lastly, it may be suggested that every man, after he is qualified, should take the opportunity of giving a few anæsthetics for emergency cases in the hospital in order to get accustomed to the responsibility of giving anæsthetics quite "on his own."

DAYS AND HOURS OF ATTENDANCE ON HOSPITAL PRACTICE

Accidents and urgent cases of all kinds are admitted by the St. Thomas's Street entrance at any time of the day or night.

THE WARDS.

Medical Wards. — Dr. Hale White (2), Mondays, Tuesdays, Thursdays and Fridays. Dr. Pitt (2), Mondays, Tuesdays, Thursdays and Fridays. Sir Cooper Perry (2), Mondays, Thursdays and Fridays. Dr. Shaw (2), Mondays, Tuesdays, Thursdays and Fridays.

Surgical Wards. — Mr. Symonds (1.30), Mondays, Tuesdays, Wednesdays, Thursdays and Fridays. Mr. Lane (1.30), Mondays, Tuesdays, Thursdays and Fridays. Mr. Dunn (1.30), Mondays, Tuesdays, Thursdays and Fridays. Sir Alfred Fripp (1.30), Mondays, Tuesdays, and Thursdays. Operations (1.30) daily.

Obstetric Ward.—Dr. Horrocks (2), Tuesdays and Fridays. Mr. Targett (2), Mondays, Wednesdays and Thursdays.

Ophthalmic.—Mr. Eason (2), Mondays and Thursdays. Mr. Ormond (2), Tuesdays and Fridays. Operations (2), Tuesdays and Thursdays.

THE OUT-PATIENT DEPARTMENT.

The days and hours of attendance in the Out-Patient Department of the hospital are as follows:—

Medical Cases.—Dr. Fawcett (1), Thursdays. Dr. Beddard (1), Wednesdays. Dr. French (1), Fridays. Dr. Hertz (1), Mondays.

Surgical Cases.—Mr. Rowlands (1), Thursdays. Mr. Steward (1), Mondays. Mr. Fagge (1), Wednesdays. Mr. Turner (1), Saturdays.

Obstetric.—Mr. Bellingham Smith (1), Thursdays and Saturdays.

Ophthalmic.—Mr. Eason (1), Tuesdays and Fridays. Mr. Ormond (1), Mondays and Wednesdays.

Dental.—The Dental Staff (9) every week-day.

Aural.—Mr. Fagge (1), Tuesdays.

Skin.—Sir Cooper Perry (1), Tuesdays.

Throat.—Mr. Steward (1), Fridays.

Electricity.—Dr. Hertz (12 and 3), Wednesdays.

Actino-Therapeutic.—Mr. Iredell (11), every week-day.

DENTAL SCHOOL.

The dental student is supplied at the Medical Office with the Prospectus, Standing Orders, Notes on Probationary Work, List of Instruments, Calendar, and Clubs' Union Book.

These pamphlets should be carefully perused in order that acquaintance may be made with the general arrangements of the school and the scope of the work upon which the student will become engaged.

Instruments having been purchased at a dental depôt, the student should satisfy himself that he has been supplied with all of those described in the hospital list.

Probationary work upon the phantom head will occupy the freshman's time for about two months. This operative course, conducted by the staff demonstrators, is very comprehensive. It includes most of the conservative operations that the student will subsequently be called upon to perform upon patients, namely, gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. These manipulations upon the dummy, when done in a thoroughly sound manner, form a capital ground-work in operative dentistry.

Pupils in Dental Mechanics are received at the hospital, and a systematized and graded course of instruction is carried out by a competent teacher.

The regulations of the Royal College of Surgeons of England require that students shall pass two professional examinations for the dental licence. At the first examination certificates must be produced, *inter alia*, of having been engaged in the practice of dental mechanics under a registered dental surgeon, or under the direction of the superintendent of the mechanical department of a recognised dental hospital, during a period of two years, and of having manufactured and adjusted six dentures and six crowns.

As this examination may be passed in the month of May the work of the first winter session should be largely devoted to demonstrations, dental mechanics, and lectures.

Students in difficulties about their work and needing advice are invited to consult the Dean, or any member of the Staff, who will be pleased to do what they can to promote the interests of students. W. A. M.

THE CHOICE OF A MICROSCOPE.

One of the indispensable adjuncts to medical study in these days is the microscope. The glowing tribute which Sir Samuel Wilks has paid to this instrument is by no means an extravagant one, when it is borne in mind how exceedingly helpful towards the acquisition of knowledge in almost all departments of science the microscope has been. To quote Sir Samuel's own words, "It has opened up a new world, and created a new science." Perhaps the student, when he comes to make his first acquaintance with these new fields which the microscope has enabled us to explore, will fervently curse the existence of an instrument which has added so much to his already crowded syllabus of work, but as he becomes more friendly and intimate with bacteriology, histology, and microscopical pathology, he will also become keenly attached to his microscope, so much so, in fact, that—as we hear on good authority—it stands very low on the list of pawnable things that medical students periodically carry under the shadow of the sign of the Medicis.

The choice of a microscope, then, is a serious matter and we would impress on the new student the importance of exercising proper care and discrimination in his selection of a good instrument. The advice and help of his teachers are always available, and it would be well for him to consult them when he has some special make of instrument in mind. For physiological purposes "the microscope must have two objectives, a $\frac{2}{3}$ inch and a $\frac{1}{6}$ inch, a nosepiece and an indicator fitted to one of the eyepieces. . . . An inferior instrument is worse than useless, for it is essential that the student should buy an instrument which will be of some use to him in future years, when, as a practitioner of medicine, he desires to examine tumours, urinary sediments, sputum, etc., for purposes of diagnosis. Antiquated instruments, such as those sometimes handed down as an heirloom in a family of doctors, are practically useless." In the biology class the student will make his first acquaintance with the use of the microscope, and although here a comparatively simple instrument with a low power suffices for most purposes, he should bear in mind that in his next year, when he comes to study histology, a good compound microscope is indispensable, and that afterwards he will want a superior instrument, fitted with a condenser and an oil immersion lens, for bacteriological work. The ideal way, of course, would be to invest in a thoroughly reliable instrument, fully fitted; but such instruments are expensive, and where money is a consideration to be regarded, a better plan would be to buy a sound stand, by one of the recognised makers, to which the various necessary addenda, such as revolving stage, condenser, etc., can afterwards be fitted At first the two objectives above stated will serve for all practical purposes; later, an oil or a water immersion becomes necessary, while a triple nosepiece is desirable as well.

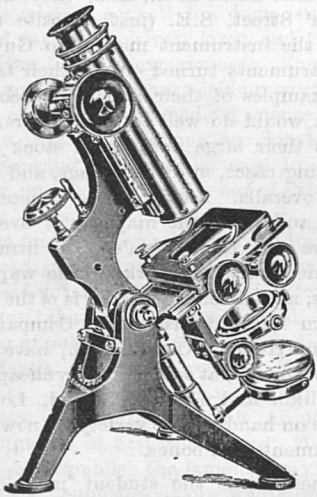
There are many standard makers whose names are recognised guarantees for the excellence of the instruments they manufacture. Of foreign makers, Zeiss and Leitz are, perhaps, the best known, and if the student is fortunate enough to be able to invest in one of their better-class instruments, he need have no fear that he will afterwards regret his purchase. These instruments can be purchased at most shops where microscopes are sold, and the Zeiss Company possesses a London agency in Margaret Street, Regent Street, W.

In choosing a microscope, it is desirable that it shall be of such a class as will meet all the requirements of the student's course. This of necessity means a considerable initial expense. Where, however, causes prevail which prevent this being done, a microscope should be chosen to which additions can be made from time to time as necessities dictate.

W. Watson & Sons, of 313, High Holborn, W.C., whose fame for British microscopes is world wide, make a speciality of constructing various parts of their instruments with interchangeable parts, and also offer high-class instruments with every mechanical convenience at very moderate prices.

For a student's microscope of proved reliability they recommend their "Praxis" model, which with 1-inch and $\frac{1}{6}$-inch objectives, eye-pieces, and case costs £6 10s., while their "Bactil" stand has been designed specially to suit the wants of the beginner, as well as those of the

most advanced worker. It has mechanical movements to the stage, giving a range of two inches of traverse, a compound sub-stage, and is supplied complete with $\frac{2}{3}$-inch and $\frac{1}{6}$-inch objectives and mahogany case for £12. Abbe illuminator and $\frac{1}{12}$-inch oil immersion objective can be added, together with triple nose-piece and an extra eye-piece, for £7 7s. 6d., making the total cost £19 7s. 6d.



Naturally, the selection is not limited to the two models that are mentioned, but either of them will be found thoroughly efficient for hospital work.

Watson's $\frac{1}{6}$-inch is a renowned lens, not only on account of its fine performance, but from the fact that it has the great working distance of one millimetre, enabling thickly covered objects to be examined without inconvenience.

Mr. C. Baker, of 244, High Holborn, W.C., lists several excellent instruments, of which his well-known "D. P. H." model, No. 1, is in every way a reliable instrument. The stand alone costs £11 11s., and the complete instrument, fitted for bacteriological and blood examination, is priced at £22. Slightly cheaper, but for all practical purposes equally good, is the "No. 2 D. P. H.," which, when fitted complete, costs £18 18s. A slight extra charge is made if the student wishes to have Zeiss lenses or Leitz objectives fitted instead of those supplied by the firm. This firm also supplies a useful and serviceable instrument for histological work, "The Model Histological Microscope," at £6 17s., to which afterwards a condenser and oil immersion can be fitted for bacteriological work.

Other good makers are Messrs. Swift, whose instruments are slightly lower in price; Messrs. Crouch, who supply several instruments suitable for students, and Messrs. Ross. From all these makers catalogues and specifications may be obtained on application. Messrs. Millikin and Lawley, of 165, Strand, W.C., list a good serviceable article in their "Stand A." model, which, fitted with mechanical stage and two objectives, and triple nosepiece, is priced at £7 6s., and to which a condenser can easily be fitted. All these instruments we have mentioned are thoroughly reliable, strongly and firmly made, and possess the usual fine and coarse screw adjustments.

For bacteriological and blood examinations the student will need an oil immersion. This can be got from any reputable maker. The Zeiss and Leitz oil immersions enjoy a world-wide reputation for excellence, although they are a trifle more expensive than those by English makers. Messrs. Watson & Son make a speciality of objectives, and their "Parachromatic series" is specially suitable for students. Their $\frac{1}{8}$, priced at £1 10s., which is supplied with their instruments enumerated above, is a particularly fine lens, giving an exquisitely crisp definition, combined with a flat field and a good working distance. Their $\frac{1}{10}$ water immersion is listed at £4, while their $\frac{1}{12}$, a new lens specially intended for the bacteriological student, is listed at the same price. They also supply a $\frac{1}{16}$ oil immersion (magnifying up to 3200 diameters, with a holoscopic eyepiece) at £6. Mr. Baker supplies a sound, reliable $\frac{1}{12}$ at £5, and a $\frac{1}{16}$ oil immersion at £6. A Zeiss oil immersion costs £8, a Leitz, £5, and a Reichert also £5. With most of these a bottle of immersion oil is supplied.

If the student is unable to go to the expense of buying a new instrument, he can often obtain a good second-hand microscope at a comparatively cheap price, and in the same way an oil immersion lens may be bought. It is advisable, in buying a second-hand instrument, to obtain it on approval, and give it a thorough trial before completing the purchase. Sometimes a bargain may be picked up at a pawnshop, or a second-hand dealer's shop; but there are several firms which deal in second-hand microscopes, and the student cannot do better than give these a trial. Their instruments are generally in good order and well preserved; in many cases nearly new. Messrs. Millikin & Lawley have a large number of second-hand instruments and lenses in stock by all the recognised makers, which they list at prices much below those charged for new instruments. Mr. Clarkson, 338, High Holborn, W.C., is another dealer in second-hand instruments whose stock is well worth inspection.

For histological work, the student will find a slide box, or cabinet, to contain his finished slides desirable. These may be bought at any microscopical instrument makers, the nearest being probably Messrs. Stanley, whose place is close to London Bridge Station.

INSTRUMENTS.

Both in the wards and in the dissecting-room and the physiological laboratory, the student will find that he needs several instruments. In the wards he will want a stethoscope, dressing instruments, tape measure, etc., and in his previous work a dissecting case is an absolute essential. The number and choice of his instruments depend to a large extent on himself. If he is sufficiently keen to think it necessary that he should possess a blood

count apparatus, pocket spectroscope, and a good ophthalmoscope, his outlay will of course be considerably in excess of what he would spend were he to rest content with possessing the absolutely indispensable only. But such outlay, we would venture to remind him, will not be money thrown away. In after years he will find the possession of these instruments not only a great help but a sound investment, provided he has invested in good instruments, which will stand the wear and tear of hospital practice. It is true all the wards possess a certain number of necessary instruments, lists of which are affixed to the cupboards where they are kept. But the advantage of possessing an instrument of one's own, independent of those that the hospital provides, is obvious. Personal possession means personal interest, and though familiarity may breed contempt, it has its advantages.

There are many instrument makers in London, the majority of whom make a point of catering for the new student. We would not advise anyone, however, to write for a catalogue of surgical instruments. These bulky volumes are so large, and contain so much, that the average student will find it a work of some difficulty to make his choice from amongst the many and various models submitted to him. Rather would we advise the new man to find out from his teachers what he needs for his work, to make a list of such instruments as he requires, and then to go to one or other maker whom he has selected, and choose his necessities from their stock. We therefore merely give the addresses of some of the better known firms, along with a few particulars of the items they stock for students.

Messrs. Allen & Hanburys, Ltd., Plough Court, Lombard Street, E.C., a firm within easy walking distance of the hospital, have a large and varied selection of surgical and other instruments. Their dissecting cases range from 10s. 6d. upwards, and are excellent value at the prices listed. They supply a special binaural stethoscope with flexible metal tubing at 12s. 6d., and have a large selection of students' dressing cases, fitted and unfitted. This firm also manufactures various models of hypodermic syringes, ranging in price from 2s. 6d. to 8s. 6d., and lists all the usual blood-counting apparatus. Their instruments are of English manufacture, thoroughly sound and reliable, and satisfactory in every way. Messrs. S. Maw, Son & Sons, 7–12, Aldersgate Street, E.C., have an equally large stock open to inspection. They list a large number of useful stethoscopes ranging in price from 4s. 6d., to an improved pattern with finger rest, catalogued at 8s. 6d. They also supply dissecting cases, dressing cases, and have in stock every kind of apparatus the student may find useful or necessary. Their instruments are guaranteed of English manufacture, and are catalogued at comparatively moderate prices. Messrs. Arnold & Sons, of West Smithfield, and Giltspur Street, E.C., who are instrument makers to St. Bartholomew's Hospital, manufacture their own instruments, and have special lines in dissecting and dressing cases for students. They also supply excellent sets of bones, half skeletons being priced from £2 19s. 6d., and disarticulated skulls from £1 15s. These sets are specially selected and may be relied upon to be sound. Further particulars of these may be obtained from Mr. Hancock in the dissecting-room. This firm lists a patent stethoscope, their "Phonophore," which has obtained high praise from those who have used it. It is priced at 6s. 6d. single tubes, and at 12s. 6d. binaural model. Messrs. Down Bros., Ltd., whose address is 21, St. Thomas' Street, S.E. (just opposite the hospital gates), are the instrument makers to Guy's Hospital, and the instruments turned out in their factory are as excellent examples of their kind as one could wish for. The student would do well to give Messrs. Down a call and inspect their large and varied stock of dissecting cases, dressing cases, midwifery bags, and last, but not least, their overalls. An overall is a necessity for the ward clerk, and by far the majority of overalls in this hospital have come from Down's. The firm supplies all apparatus necessary for work in the wards or in the laboratories, and all their material is of the best quality. The Holborn Surgical Instrument Company, Ltd., 26, Thavies Inn, Holborn Circus, E.C., have also a large stock of instruments, at comparatively cheap prices, while Messrs Millikin and Lawley, Strand, London, W.C., have always on hand a large variety of new and second-hand instruments and bones.

At all these firms the student may obtain blood-counting apparatus, ophthalmoscopes, pocket spectroscopes and other desirable, if not absolutely indispensable, instruments. Messrs. Watson & Sons, of 313, High Holborn, and Mr. Baker, of 244, High Holborn, however, list special sets of blood-counting apparatus designed for students and clinical use, and in addition stock several sets of microscopical apparatus, including stains, etc. Messrs. Stanley, Station Approach, London Bridge, who are *opticians to Guy's Hospital*, have a large and extensive stock of microscopical apparatus, such as slides, specimen boxes, etc., and their shop is conveniently situated for those who cannot afford much time. Their articles are of excellent manufacture, and thoroughly satisfactory.

As in the case of microscopes, the student can often obtain second-hand instruments at a comparatively cheap price. Sets of bones discarded by those who have no longer any pressing need for them may often be picked up cheaply, and the student would do well to interview the dissecting-room attendant (or the commissionaire who will usually be found in his den underneath the Medical School Buildings). From both second-hand scalpels, forceps, or complete dissecting cases may sometimes be obtained. In buying second-hand instruments the student should assure himself that the articles are sound and reliable; if at all in doubt his demonstrators will always be ready and willing to help him in deciding whether to buy or leave them. There are several second-hand shops in the Borough at which instruments and bones can sometimes be picked up for a mere song, and those who cannot afford to go to much expense will

do well to pay a visit to these places and see what may be obtained there—always bearing in mind that many of the things shown in their windows are comparatively obsolete, and that any instrument decided upon should be tried and approved of before it is bought.

BOOKS.

The student who wishes to obtain his books at once should not take the first he sees on any particular subject, but would be wise to consult his demonstrators first; the number of text-books is very large, and the choice is a difficult matter to the inexperienced. Roughly speaking, second-hand books are very seldom worth anyone's while to buy, chiefly because medical science is progressing so rapidly that new editions are constantly being published. Especially is this the case in Physiology, where a book may become quite out of date in many points in the space of a couple of years. The other sciences of the first and second years' study are scarcely less pronounced in this progress. Hence a student is strongly advised not to purchase his books for his second year's work until that year has commenced.

The number of publishers of books for medical students is great. Messrs. Churchill publish Taylor, Jacobson, Goodhart, Fagge, and many other well-known works. Messrs. Macmillan publish Allbutt, Foster, and a great number of first-year books; Messrs. Longmans, Green & Co. publish the famous Gray's Anatomy. Mr. Murray also publishes many well-known medical books, as also do Smith, Elder & Co.; Philip & Son; H. K. Lewis, and Cassell & Co.

As we have mentioned, it is rarely that second-hand books will be required, but there are cases in which they are valuable. Mr. Chas. Sawyer, 29–31, New Oxford Street, W.C., has a long list of last editions at very moderate prices, and there are other second-hand booksellers.

All books can be obtained from Mr. H. H. Grattan, in Borough High Street, who is the "official bookseller" to the hospital. Many well-known books he can supply over the counter; any others desired he will have in an hour or two.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Blue Book.

DEAR SIR,—Will you again permit me to call the attention of those of your readers who are Life Members of the Union to the present edition of the Clubs' Union Year Book, which is being circulated this week from the printers? The current issue has been enlarged with the idea of making the book more interesting to old Guy's men, some twelve pages of "Occasional Notes" having being added to it.

In order that we may obtain more complete information from foreign parts, I am writing to Guy's men in South Africa, India, Australia, and New Zealand, inviting about a dozen men to undertake the duties of branch secretaries. It is hoped that these correspondents will furnish the Secretary of the Union, at least once a year, with some account of the doings of Guy's men in distant parts. We also hope that everyone will return, with corrections or additions, the pink slip which is sent out in every copy of the Year Book, and that no false sense of modesty will deter any of those to whom honours and appointments have fallen from forwarding information which cannot but redound to the world-wide fame and name of our old hospital.—I remain, dear Mr. Editor, yours very truly,

HAROLD CORRY MANN,
Sept. 14th, 1908. Hon. Sec. Clubs' Union.

Newspaper Science.

DEAR SIR,—The enclosed cutting, which was taken from the leading columns of a provincial paper, may, I think, prove entertaining to some of your readers. The writer of the article, it appears, has not been blessed with a scientific education, and hence his inability to understand the views of Mr. Francis Darwin is pardonable, but he would perhaps have been wiser had he refrained from publishing his own interpretations of this great biological discourse.—Yours, etc.,

Brighton, J. A. RYLE.
September 10th, 1908.

[Mr. Ryle encloses a newspaper cutting—too long to reprint *in extenso*—dealing with the Presidential address at the British Association of Mr. Francis Darwin, whom the writer persists in styling "Dr." The whole article is written in that vein of half-interested, half-amused condescension towards science sometimes adopted by the scientifically ignorant. Mr. Ryle draws attention to the following passages:—

> What is ontogeny? It is, we presume, a process of development, either in plants, in the lower animals, or in man. *The epigenetic point of view, we may similarly surmise, is that of those who hold that the germ of an organism does not pre-exist in the parent, but is brought into existence by the parents' powers of procreation.*
>
> *Here, again, we pause to inquire who and what are the somatists? They are those who believe in the inheritance of acquired characters. The designation, which is new, is rather far-fetched, but has a certain applicability, soma being the juice of a plant offered in libation to a Hindu god to strengthen him in his fight with the demons. It is identified—and here its applicability comes in—with the invigorating and immortalising principle in nature.*

The writer's derivation of the word "somatic" from the sacrificial drink of the ancient Hindus has a certain picturesqueness which he evidently finds lacking in Mr. Darwin's address, for he complains that the President "spoke to scientific men only in terms of science, and we regret to say without any fascination whatever."—ED.]

AT OUT-PATIENTS.

"Do you drink much beer?"

"I only 'as abart twenty pints a day, Sir, but sometimes I do 'ave a lot."

Experiences of a Medical Motorist.

IN response to the request in the GAZETTE, I am recording my experiences as a motorist for the last year, in the hope that they may be of use to others.

My first car was bought for me, second-hand, by a man to whom I was introduced, and who was said to have a thorough knowledge of motors and the motor trade. It was an 8-h.p., two-cylindered French car, of antiquated pattern, which had had very hard wear, as it afterwards turned out, with its former owner. I had a lot of trouble with worn engine-bearings, soft gear wheels, inadequate water circulation (the pump was driven by friction off the fly-wheel), and various minor defects. However, it taught me much about the anatomy and pathology of the petrol engine, although the lesson was a costly one.

In May of this year I sold this car, and bought my present 10–12-h.p., two-cylindered, four-seated British car. This make has done remarkably well in the Scottish and Irish Reliability Trials, and I had seen several of the older pattern cars, which had been running for some time, and which showed no signs of wear. This car has been in daily use since the end of May, and has travelled quite 2,000 miles, and is running now better than ever. The construction is very simple, and the working parts are easily accessible. The ignition is by coil and accumulator; the water pump is gear driven off the timing shaft with tubular radiator and fan; the gears show no sign of wear, and are operated by a gate-change, a great improvement on the older quadrant type of change. The car is remarkably quiet in running, comparatively dustless, and I can average twenty-five miles to the gallon of petrol on a round, including numerous stoppages. The spark and throttle are controlled by levers working in a dial on the steering wheel, and a conveniently placed accelerator pedal also controls the throttle, enabling it to be opened up from a point set by the steering-wheel lever, thereby leaving the right hand free to work the horn or gear lever. The carburettor—a new type fitted this year—is a thoroughly good one, the engine responding at once to any alteration in the throttle opening, and running, if need be, quietly and evenly at a very slow speed. The amount of air admitted to the carburettor is regulated by a lever on the dash, the mixture being thereby varied to suit the weather or the work required from the engine. The engine will start, as a rule, at the first or second turn of the handle, *without* flooding the carburettor. The clutch is of the leather-faced type, and acts with remarkable smoothness. The transmission is by cardan shaft and live axle, all universal joints being enclosed in dust- and oil-tight metal cases, with ample provision for lubrication at all points.

My car is a four-seater, but a two-seated model with the same engine is made. It is, however, a great luxury to be able to sit behind and be driven, especially when tired. Any handy man or ex-coachman can learn to wash the car, and a short time each morning spent on lubrication is all that is required. Personally, however, I keep a lad of nineteen specially for the car; he cleans and looks after it generally, and shares the driving with me, and when one is busy it is a great comfort to feel that one need not spend any time or soil one's hands before going out.

My repairs, so far, consist of a new carburettor float and new petrol tap. Both of these leaked soon after I had the car, and were at once replaced by the agent. Except for some slight damage to coachwork and a lamp, due to a collision (covered by insurance), there has been no need to trouble the repairer at all. A slight misfiring at one time was put right by cleaning the sparking-plug points and adjusting the coil tremblers, and, beyond the ordinary routine work, this is all that has ever been needed. The accumulators run for about a month before being recharged, and the car will run very well indeed with as low a voltage as 3·8.

I may, perhaps, summarise my ideas of motor cars in country practice thus:—

1. *Don't* buy a second-hand car unless you know all about it, and have it reported on by an independent engineer.

2. It pays to give a good price for a reliable car by a good maker. First-class material and workmanship are essential for hard wear, and these must be paid for. Cheap cars are often very troublesome.

3. Be content with moderate power. Four cylinders, of course, develop more power than two, and require more looking after and consume more petrol as a rule.

4. Buy, if possible, from a local agent, who will deliver the car to you, thoroughly tuned up, free of all cost for carriage from works, and whose interest is best served by selling a thoroughly satisfactory article.

5. Such extras as voltmeter, tyre-pressure gauge, and vulcanizer, while not absolutely essential, are often of great convenience, and will save their cost before long.

6. The advantages over horse traction are obvious, for less time is spent on the road, enabling one to give more time to one's patients, and to spend more time at home. Fatigue is lessened greatly; one can take little pleasure trips which were impossible before. It is possible to get away at night far more quickly than with a trap, and one need not think of the horse and man being left out in the cold.

As the columns of the GAZETTE are not intended for gratuitous advertisements, I have purposely omitted to specify the make of my car. I shall, however, be pleased to give the name, and any further information in my power, to anyone who will send me a stamped and addressed envelope.

KENNETH ANDERSON, M.B.

Eversleigh,
Banwell, Somerset.

A Critical Aspect of Modern Dental Education.

BY HAROLD G. SPAIN.

MR. PRESIDENT AND GENTLEMEN,—It is with considerable trepidation I am introducing to you this evening a paper on Dental Education. For I am perfectly aware that you are compelled to interest yourselves so much in this subject while at work that you would willingly shun it when at recreation. Yet when we realize its tremendous influence on our after-life, and its remarkable potency for good or evil, then we must feel that any changes in it must of necessity concern us very vitally indeed as future professional men. To properly appreciate its significance, we have but to remember that it is simply a continuation of our scholastic career; with just this slight difference, that it specializes.

Then just as the general habits formed at school influence us in the acquirements of those special technical ones at Hospital, so do these brand our work in our future qualified lives. Thus it is clear to see that if we are taught to be proficient we shall remain so, and *vice versa*. My reason for regarding these obvious truisms as such significant factors in our future careers is that they depend considerably on external influences, and as such, we are not able to determine the lines of our own education, but have perforce to adopt them because they are the joint efforts of our governing bodies, the General Medical Council and the Royal College of Surgeons, and so this plaintive wail of discontent, if joined by a united howl from you, will raise it from that of a weakly babe to a roaring lusty infant determined to enforce its rights from a heedless parent.

However, as is true in all things, we must be certain what we want before we agitate for it, and so it is first necessary to define what we should represent as a dental surgeon, as this ideal represents the aim of our existence here.

This, gentlemen, is one I put tentatively before you as embodying the chief essentials of such a person :—"He is a highly-trained specialist in the theory and practice of that branch of surgery which deals particularly with the teeth and other allied parts of the human body, and is enabled by his education to have just sufficient knowledge of those other human diseases which occasionally may be either the causes or results of dental affections." It is now easy to define an ideal education meeting the needs referred to above.

We see that such an education should give us a thorough knowledge of all the various phases of dental surgery, and also enable us (quoting the above definition) "to possess just that sufficient knowledge of those other human diseases which occasionally may be either the causes or results of dental affections." That, and nothing more, gentlemen, I contend is necessary. But when we turn and peruse that highly interesting little brochure issued by the Royal College of Surgeons, called affectionately by us "The Syllabus," we cannot help feeling it falls lamentably short in this aim.

Perhaps at one time the subject of "Training us up in the way we should go" interested them a little as a hobby, until they found their endeavours to create nice little educational schemes for our benefit aroused a certain amount of discussion, and in a childish fit of temper, or wounded vanity, they threw together this beautifully inefficient and totally illogical scheme of education, which is embodied in that monumental result of their intelligence called "The Syllabus."

One feels tempted to sum up this representation of their intellectual discernment of our needs by crying that "They make us do the things which we ought not to do, and leave undone the things which we ought to do, and there is no hope in us." It therefore remains for us to see how we can improve upon it.

Now, gentlemen, it is, I consider, most necessary to thoroughly realize that we are specialists in an age of very great specialism, and so any work we have to learn which does not directly or indirectly come within the scope of the aforementioned definition, is absolutely useless to us; for not only does the pursuance of these subjects waste actually so many of our valuable hours, but it prevents us during that time from assimilating more practical knowledge invaluable to us as future dental surgeons.

I will now proceed to criticise this dental education in detail, in order that we may determine what is necessary or unnecessary. The first examination we are concerned with as students is that one which is called the Preliminary Science. In this many beneficial changes might be introduced to make it more helpful to us in our after-studies, which I will discuss a little later. Dental Mechanics and Dental Metallurgy form the next item, and these I consider, in somewhat modified forms, should be passed before entering the hospital. Also

that the lowering of the pupilage to two years is a mistake, for a thorough mechanical training is the foundation of success. But fearing lest these revolutionary ideas may incapacitate you for discussion afterwards, I will endeavour to vindicate them in a scheme to provide a reasonable and logical scientific education.

At the outset it is perfectly apparent we must not follow that wretched tendency exhibited in the Syllabus of sprawling the study of some subjects throughout the whole course. One example of this may be cited—the attendance of men in their first week and onwards at the Dental Anatomy Lectures.

Do you not see the unreasonableness of this stupidity? A builder does not start to fix his chimneys while laying the foundations of his house, nor does he slate his roof until his walls are up to support it. It is simply a natural law that any result to be achieved must be built up step by step, with each one in its own definite place. They cannot be just slung together without any attempt at chronological order. So I have endeavoured to formulate a system in which every necessary subject is learnt and done with at the most advantageous period in the student's educational life.

In the first place, there would be an apprenticeship on a sliding scale, from two and a half to three years, the regulation of which I will explain later. This would take place either at a hospital or with a dental surgeon. During this time he would study a revised course of chemistry and physics, so altered that it would contain the essentials of dental metallurgy. In this part of his science examination he would have to know the salient features of the subject as expressed in Smith's Dental Metallurgy. But there would be no attempt to reduce the wretched youth to insanity by cramming him with complicated tables of specific gravities, etc. Any little practical metallurgy on assaying considered necessary might easily be done in one of the afternoons he spends in the chemical laboratory. You can thus see how many hours of useless occupation would be saved him when at hospital.

This chemistry and physics examination, plus the amount of aforementioned metallurgy, would be passed at the end of the first year. Then, during the course of the second year, the apprentice would prepare for a simple examination in biology. No doubt many of you now will call me inconsistent, and are ready to hurl back my definition at me, saying you fail to see the application of this subject to dentistry. To those gentlemen I remark, as explanation, that biology offers up an easy and interesting way of learning the elements of anatomy and physiology which become indispensable to them afterwards, and it serves to render their study much quicker when at hospital. This examination would be the one that is set in the First Conjoint, and would involve, perhaps, six to nine months' evening study—certainly, not more.

Thus we will presume the student has passed these two examinations after eighteen months apprenticeship. He would now work exclusively at mechanics for a year, when he would have an opportunity of presenting himself for examination in this subject. He would be required to do the following work: an all metal and a porcelain face crown, a side metal case and any other mechanical work which is done every day in the workshops, because I maintain that if a man is to have a thorough training he must be able to do everything up to a certain standard which need only be that of accuracy and comfort in the mouth.

I therefore propose that in this examination the models to which he works would, if possible, be those of people desiring appliances, and so his test would simply be whether or no his work gave satisfaction in the mouth. And after all you would only be testing his skill by the standard to which he will always have to work. And thus we know when he reaches Hospital he would be proficient in this branch of study and so have done with them for good, at any rate during his hospital career.

The course of education at hospital would be divided into two distinct halves, theoretical and practical, and his method of learning them would differ essentially from the present system, inasmuch as no practical dental work would be done until he had completed and passed his theoretical studies. In my opinion this procedure would possess two advantages; first, he would have all the theoretical knowledge at his finger-ends on his first entrance to the Conservation Room, and so would grasp much quicker the practice of dentistry, the technique of which is of course founded on theory. Secondly, he would have all day for his practical work, and there would be an end to that harassing practice of sandwiching in lectures and study with the attendance on patients, to the detriment of both. The advantages of this are obvious.

The next examination would be the second professional, of which all the subjects in the first part are necessary, indeed fundamental, but it is my contention that they are taught in a futile manner. Just consider a moment how widely our Syllabus for this examination differs from

that of the Second Conjoint. Yet, incredible as it seems, we are forced to attend the same lectures and the same number of them as the medical students who are working for that examination. Where, then, is the logic of such a scheme? We know that nearly all those official hours of anatomy and physiology are an absolute waste of time to us, and yet they represent in six months some thirteen days of eight hours each.

We learn these subjects chiefly by dissecting and private study, also from the series of homely little lectures arranged for us by our Hospital, such as bone, revision and coaching classes. These same remarks apply to the Official Surgery Lectures, where another thirty hours are more or less wasted, because the hospital already provides for our education in this subject by means of lectures at twelve o'clock on Fridays, which are adequate. What, then, is the good of those other lectures insisted upon by the Royal College of Surgeons? But the last straw on our heavily-loaded backs is a series of compulsory medicine lectures; at which we learn how horribly unpleasant it is to have cancer of the rectum, and what dangerous things stones in the bladder are! I presume as we have to attend these lectures they refer to carborundum stones! But I cannot conceive how they got there, and it is difficult to see, even if I did know, how it would help me to do a porcelain inlay or extract a refractory wisdom.

No, gentlemen, I find no place for them in this scheme; for if you still imagine there to be an intimate and subtle relation existing between tape worms and gold inlays, you must fly to your dental text-books. You will not find it in the medicine lectures. However, they very wisely do not examine us in this subject, and there remains nothing to do but shed a tear over those hours of wasted time, and resume our discussion.

Then, during the first year at hospital, the student would prepare for an examination in anatomy, physiology, and surgery. That is, he would spend his days very much as a Second Conjoint man—dissecting, learning his anatomy, physiology, and surgery. During this period I should include a series of lectures on dental materia medica. They would convey to the student the general principle of drugs and their actions, also how to prescribe them, with sufficient knowledge of those drugs most commonly used by us. He would also learn a little toxicology. You think it unimportant? Well, let each student present ask himself what remedy he would administer, instantly, to a patient who has inadvertently swallowed a crystal of $Hg\,NO_3$, which he was applying to his tooth.

If you *know*, gentlemen, I deny you got it from a lecture. If you have no knowledge on the point, the unpleasantness of this state of mind may strike you at some future time, as your patient fast drifts into the land of shadows. But you would have the consolation of stating at the inquest that this was one of the very few points upon which your education did not enlighten you. Of course, I know this is not a usual occurrence, but it *is* a possible one, and the aim of the class would be to safeguard you against all possible emergencies of this kind. It would teach the student the advisability of knowing the official doses of such drugs as strychnine, morphia, cocaine, etc., and impress upon him that quite nasty little accidents do happen, if by mistake he administers hypodermically the amount considered necessary *via* the mouth, and show him that the present of an anchor with forget-me-nots, though a thoughtful idea in itself, would not quite atone for the mistake. Thus he would pass an examination on maximum and minimum doses of poison, etc., and would be *au fait* with the drugs in use every day. He would also learn the compounding of simple things, as tri-cresol and formalin, carbolised resin, etc. They are to be made, gentlemen, much cheaper than they can be bought. The results of this class would be embodied in a Guy's Dental Hospital Pharmacopœia, the profits on which would be utilized for an ambitious scheme to provide hot and cold water in the Conservation Room.

Some of you may argue all these things can be found in books. While not entirely agreeing with you, I maintain this knowledge should not be left to your inclination or disinclination for acquiring it, because it is a duty owing to the public that you are not only qualified, but competent to act, and the Royal College of Surgeons should be the guarantors. This finishes our general examination.

As regards dental surgery, it is, of course, absolutely essential; but when we come to study the question of dental and comparative dental anatomy we are lost in admiration of the effectual method for rendering us the laughing-stock of more enlightened nations. As regards dental anatomy, a few lectures would serve to teach us all we should ever have reason to know concerning the elements of histology, etc., of the teeth. But it is our first encounter with comparative dental anatomy that dumbfounds us with the barbaric fiendishness displayed in

such a scheme of mental torture. Who has not heard the qualified man remark, "You will have forgotten it all in six months?" There may possibly be a germ of usefulness somewhere in it, but this could be learnt in some two or three lectures; but to raise the subject to such a pinnacle of prestige that we are compelled to do homage to it by examination, and to sacrifice some six months to its study, is nothing short of monstrous. Has it never struck the Royal College of Surgeons that a knowledge of general anæsthetics might be considered by our patients as a handy little thing to have about us?

In my scheme, during the first six months of his second year at hospital after his general examination, he would merely have the study of dental surgery, anæsthetics, probationary work, and any other classes which might be found desirable. These again would be passed at the end of this time. He then has a whole year for the acquirement of manipulative skill, and if you consider that some of you finish your fillings now with attendance at lectures in that time, it is easy to see that working all day you would be able to do a great deal more.

As regards anæsthetics, you will find at present that it is left to your discretion or indiscretion whether you leave the hospital entirely ignorant of anæsthetics and their use and abuse or otherwise, for none of the lectures on the subject are compulsory. Surely this is wrong, gentlemen; it is unfair to you and a breach of faith to the public, for if the subject is of so little importance that you may entirely qualify without attending a lecture and having had no practice at all—why should the unqualified man be had up for manslaughter in a fatal case? In this respect he is no more unqualified than you are, and he is not cloaked in a garb of hypocrisy.

I maintain that there should be a series of lectures and demonstrations necessitating compulsory attendance, where the student would not only give the anæsthetic, but when proficient in this stage he would both anæsthetise and extract. This is merely what happens to us in private practice, for although some of us dream of always having medical assistance — yet in many cases the reality will fall short of the ideal, and unless we do both these things, that everlasting bogey in the shape of the unqualified quack will oblige, and your erstwhile patient's life will be jeopardised.

Another point as regards this subject is that legally the operator is responsible for the termination of the operation, whether fatal or otherwise. This sounds unfair, gentlemen, but does it not impress upon you more than ever the desirability of an efficient knowledge of anæsthetics? Similar classes would be held in anæsthetics, and the student would leave the hospital not entirely an ignoramus on this point. Also, a course on crown and bridge work might be introduced, a little fuller than the one at present here in vogue. These classes need not make the course any longer, for the student might save six months of his apprenticeship as explained before, and this means he would get two and a half years' mechanical dentistry, and two and a half years' hospital work to make him a proficient dental surgeon.

And now before summing up there is one statement I wish to make, and that is this: I do not want you to think I represent this as an ideal education under *any* set of conditions, for any educational scheme must be regulated by the fact that the period of study at hospital is very short. Although the student now gets his mechanical work done in two years, it does not mean he spends three years at hospital. I think you will find it has merely reduced the period of study to four years. So, therefore, I want you to judge this scheme as applying to a two and a half years' course at Hospital, which would make the total period five years. If a longer course were introduced, obviously this scheme could be amplified with advantage.

Before finally closing this paper, I should like to place before you a summary of the faults of the present education, which I have just explained in detail. Firstly, it is an education which was suitable for a bygone age, when dental knowledge was very scanty, and in order to raise the standard of the profession it was necessary to introduce some other subjects, with the object of making rigorous examinations requiring a long course of study.

Secondly, that as now we are in possession, comparatively speaking, of such enormous knowledge of this branch of science, there is more than enough to learn and apprehend without any appeal to subjects outside our range of interests, except in a nearly negligible degree.

Thirdly, it is, therefore, imperatively necessary that our whole education should be revised and modernised to meet the demands for a *wider manipulative training and technique*, in which, for instance, the test of a man's manipulative proficiency should not be all at stake in the result of the one gold-filling that he does in his final examination.

Fourthly, that the study of such subjects as dental metallurgy, comparative dental anatomy, and dental histology should be reduced to a minimum, only the absolute essentials being

taught, and the time saved would be devoted to higher instruction in such practical work as crowning and bridge work, regulation treatment, etc.

Lastly, in your fight against the quack, the one and only efficient weapon you can ever possess is superior manipulative skill, and this is my reason for so labouring on the desire for a more practical education. You will not gain patients by eloquently conversing with them on the dentition of the primates, but the quack *will* lose them eventually if he does not possess your superior skill.

And now, gentlemen, nothing remains for me to do but thank you all for your patient courtesy in listening to me, and if this paper has wholly or partially convinced you that a more modern education is necessary and desirable, I shall be well satisfied.

The Recantation.

Suggested to a former Guy's student, now a fashionable physician, by reading Chant-Pagan by R. K., to whom apologies are due and tendered.

I that have been what I've been,
I that have gone where I've gone,
I that have seen what I've seen—
How can I ever keep on,
With lackeys to take off my hat,
And footmen each side of the door,
When I call on the duchess's cat,
And the dowagers sit there and preen
Their plumage with scandal galore,
I that have been what I've been?

I that have passed through the fire,
When the issues were hid from the gaze,
And Death was at hand-grips with Life,
And the balance would waver, that sways
On the point of a small steel knife.
Till sudden there came the decree,
And a soul hurried back to its care,
And the mind of the surgeon was free
To weigh out more life with a hair . . . .
And I shampoo a sick millionaire.
Me!

I that have slaved, when the tide
Brought a fresh cargo for Death,
Sweat running down from my face,
As I pumped at the labouring side.
Till the pain stabbed me through with each breath,
Till the lightnings flashed right through my head,
And the patient, ungrateful, was dead,
And the night nurse would fain sympathise
With her shy irrepressible eyes . . . .
I'm treating the cold of a dog
Which belongs to a Princess incog.,
And: "Mind you wrap Phroso in lace!"
Me!

I that have tramped through the dawn
To the heart of a polyglot slum—
Would to God that its darkness were dumb!—
Where the filth underfoot was the least,
And Hunger stalked Crime through the street,
Where shadows would moan as I passed,
And bobbies walked two on the beat,
And my passport—a dirty black bag . . . .
Now Fashion's tied me to its drag,
And my lord and his lady must call,
(Not to speak of His Fatness in lawn,
When a fever comes after a feast,)
And they faint if I just lance a gum,
Though I've learned to lisp "Damn" in a drawl,
With kid gloves on the altar of Caste.
Me!

I that have been where the Fates
Threw back the old furnace gates,
With the heat and the sweat and the glare,
The furnace where plain man is made.
Where passions flash red through the dark
Of Poverty, Labour, and Pain,
Where the soul on the anvil is stark,
And the strength's hammered into the blade.
But I'm here where there's little but dross,
In spite of the polish and gloss;
Very pretty, but too little wear,
And the metal wants forging again.
Me!

Am I but a Prodigal Son
Fit herd for these dainty-fed swine?
Ay, dainty, but only on husk,
And I'm tired of this bend in my back,
And I feel there is something I lack,
'Mid these pearls and the silk and the musk.
For I know of a dingy old place,
Where there's little of velvet and lace,
But only much work to be done;
And a man who would make me feel glad,
If I only caught sight of his face,
In the stuffy old room that I had,
Where the breezes were laden with tan,
But there flowed, when the feasting began,
The Cup wherein Life is the Wine.
Let me hence and once more be a Man.

F. B. BROOK.

BOOKS RECEIVED.—Cooper's Sexual Disabilities of Man; Carnegie Brown's Spine and its Treatment; Calmette's Venoms and Venomous Animals; Hutchison's Applied Anatomy; Groves' Synopsis of Surgery; Husband's Practice of Medicine.

Guy's Hospital Clubs' Union.

THE FORMATION OF THE CLUBS' UNION, by the amalgamation of the various constituent institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the clubs and societies existing at the hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription (see Clubs' Union Blue Book, p. 13) to the Clubs' Union, any student of the hospital can obtain the privilege of membership of the constituent institutions.

THE GROUND OF THE CLUBS' UNION, which is under the control of the council, is situated close to Honor Oak Park Station, on the London, Brighton and South Coast Railway, and to the Crofton Park Station on the South Eastern and Chatham Railway. It is nine acres in extent, and is the headquarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. Return tickets at single fare are issued by the Brighton Railway Company. Under such restrictions as are found necessary by the committees of the several clubs, and are approved by the council of the Clubs' Union, every member of the Union has opportunities of practising and taking part in matches, and in the various sports and games. There is a large pavilion upon the ground, with dressing and lavatory accommodation. Refreshments can be obtained by members of the Union according to the tariff of the Students' Club.

THE HOSPITAL "BLUE."—The "Blues" Committee, consisting of two representatives from each associated club, award "Blues" and "Half-Blues" to members of the following teams:—Rugby Football, Association Football, Cricket, Athletic, Lawn Tennis, Hockey, Gymnastics, and Water Polo, after considering the list of men suggested by the various Clubs' Committees through their delegates. Blues are awarded half-yearly, at the end of each session, so that the Rugby Football team be represented by fifteen Blues, the Association Football by eleven Blues, Cricket by eleven Blues, and Lawn Tennis by six Blues. Blues and Half-Blues are awarded for Athletics, dependent on the recommendation of the Athletic Committee according to the performances at the Inter-Hospital Sports, while there are allotted to the Water Polo Club seven Half-Blues.

CONSTITUENT INSTITUTIONS.

THE CRICKET CLUB.—President: Sir Alfred Fripp, K.C.V.O., C.B., M.S.: Captain: F. Kahlenberg; Hon. Sec. and Treasurer: M. M. Munden.

Matches are played throughout the summer session, fixtures being made for three XI.'s. There are both a Senior and Junior Inter-Hospital Cup. Guy's has won the Senior Cup fifteen times since its inauguration in 1882. The Junior Cup has been in existence five seasons. Guy's has won it twice.

Practice matches are held early in May, and all freshmen should put their names on the list. Blues are given to the members of the Cup team, and Half-Blues to some members of the 2nd XI.

The Annual General Meeting will be held in March.

THE FOOTBALL CLUBS.—President: Frederick Taylor, Esq., M.D. Rugby—Captain: L. B. Stringer; Hon. Sec.: A. H. Crook. Captain 2nd XV.: E. L. Elliott. Captain 3rd XV.: W. P. Vicary; and a committee of five, one representing each year. Association—Captain: C. A. Wood; Hon. Sec.: C. Witts. Captain 2nd XI.: D. A. Mitchell. Captain 3rd XI.: W. A. Matthews: and a committee of five, one representing each year.

The Rugby Football Club has now been in existence for over sixty years, the season 1908–1909 being the sixty-fourth. Very little is known of its early history. Among the many well-known players who at one time or another have played for Guy's may be mentioned the following International footballers:—A. W. Pearson, W. W. Pinching, A. H. Jackson, L. Stokes (Captain 1877–8), A. S. Taylor, W. G. Mitchell, A. Allport, H. W. Dudgeon, A. Alcock, H. Lee (England); H. H. Jordan, E. Morgan (Wales); R. Evans (Scotland); F. O. Stokes (Ireland).

The Inter-Hospital Challenge Cup was instituted in 1874, and Guy's had the honour of being the first holders. Since then Guy's has held the Cup eleven times, St. Thomas's ten times, London five times, St. George's three times, St. Bartholomew's twice, and Middlesex and St. Mary's once each. In 1891, Guy's, Middlesex, and St. Thomas's were left, the ties not being played out.

Last season we beat St. Bartholomew's after playing one drawn game. We also beat St. Mary's, thus getting into the Final v. London. This game we unfortunately lost, London thus regaining the Cup which we had taken from them the year before. Except for this unfortunate finale, last season was a most successful one; we did not lose a match till February 15th, when we lost to Plymouth, at Plymouth. We won 16 matches straight off the reel, our season's results, excluding Cup ties, being: won 17, lost 2, drawn 1. This is a record which, although hard, we hope to excel in the ensuing season, if only the men continue to show the same keenness as in former years.

The 2nd and 3rd XV. both did very well. The 2nd XV. regained the Junior Cup, which they lost last year.

The hot-water installation at Honor Oak Park was much appreciated last year.

The ensuing season's fixtures for all three XV.'s are very good, and trial games will be played in the first week of October. For the benefit of freshmen in particular, we may state that lists will be put up in the Smoke-room, on which intending players should write their names as soon as possible. The officers of the clubs will at all times be very glad to give any information in their power.

The Association Football Club "first saw the light" in 1882, and a high measure of success has rewarded its efforts from its earliest days. Four years later (1886) the Inter-Hospital Challenge Cup (Senior) came into existence, and of the twenty-three occasions it has been competed for, Guy's have "been on top" no fewer than eleven times, St. Bart.'s being our nearest opponents with five wins. In its very palmiest days, Guy's also won the Surrey Senior Cup, viz., in 1887 and 1889. Last year we wound up a very successful season by beating University College Hospital in the final by 6–0. We also won the London University "Soccer" Cup. This Cup is open to competition by all the recognised schools of the University, and came into existence last season. In this competition we scored 22 goals against 2, overcoming East London College in the final by 5–1. In 1898 the Inter-Hospital Junior "Soccer" Cup was competed for for the first time, and of the eleven finals we have won five. Last season the 2nd XI. beat St. Thomas's in the final by the narrow margin of 1–0, and had quite a busy and successful season. Surely three cups in one season is a good enough record for any Hospital club!

And now another pleasing item—the revival of the 3rd XI., who had a very encouraging season indeed, and in no mean measure contributed towards the successes of the 2nd XI. May such keenness and happy results follow the club during the coming season!

Early in October trial games will be arranged to take place at Honor Oak, more especially for the benefit of "freshmen," and it is to be hoped that no freshman interested in Hospital "Soccer" will hesitate, *for any reason whatsoever*, to avail himself of this golden opportunity of proving his worth on the field, for it is largely on the result of these games that his subsequent inclusion in the team depends. Notices of such trial games will be posted in the Smoking-room of the College. A complete list of the season's fixtures will appear in our next issue.

The club has entered for both the Surrey Senior and Junior Cups. It may be added that the club has joined the Amateur Football Association.

THE LAWN TENNIS CLUB.—President: W. Arbuthnot Lane, Esq., M.S.; Vice-President: J. Fawcett, Esq., M.D.; Captain: F. J. Cutler; Hon. Sec., H. Sharpe, and a committee of six students.

The Lawn Tennis Club was founded in 1888. Two teams are run during the season, which starts on May 1st and finishes at the end of July. There are two Inter-Hospital Cups. This year we won both the Senior and Junior Cups. Last year the first six were runners up, being beaten by St. Thomas's in the final, and the second team were beaten in the first round. A trial game is held early in the season, and tournament singles are played during the session for the Arbuthnot Lane Cup.

THE ATHLETIC CLUB.—President: J. Fawcett, Esq., M.D., F.R.C.P. Hon. Secs. and Treasurers: S. H. Browning and R. G. Oram, and a committee of eleven. The annual summer meeting is held in June, when the Lucas Challenge Cup is competed for, at the Clubs' Union ground. The team which represents Guy's in the Inter-Hospital Sports is chosen on the results of our sports. Blues and Half-Blues are awarded at the discretion of the committee. There is also a contest between the United Hospitals and Dublin University annually.

In connection with the Athletic Club there is a Cross-Country Club, which has runs every Saturday, and races with the leading London clubs, and the Universities of Oxford, Cambridge and Dublin. Half-Blues are awarded in the Inter-Hospital Cross-Country race. Full particulars and notices of all club matters are to be found on the colonnade notice-board.

THE RIFLE ASSOCIATION.—President: Sir Alfred Fripp, M.S., C.B., K.C.V.O.; Vice-Presidents: G. Newton Pitt, Esq., M.D., L. A. Dunn, Esq., M.S., M. S. Pembrey, Esq., M.D., A. P. Beddard, Esq., M.D., R. P. Rowlands, Esq., M.S.; Capt.: H. J. Henderson; Hon. Sec. and Treasurer: W. E. Wallis; Committee: C. B. Ticehurst, L. L. C. Reynolds, H. L. Attwater, C. C. Holman, G. A. Blake, G. B. H. Jones, and W. Robinson.

This Association, which was founded in 1883, is a constituent unit of the Clubs' Union, and all members of the latter are, *ipso facto*, members of the former, without extra subscription. Any Guy's man not a member of the Clubs' Union can join the Association by an annual payment of five shillings. A Hospital Half-Blue is allowed to members of the team.

The Association is one of those forming the United Hospitals' Rifle Club, so that all Guy's men have the use of the United Hospitals' targets at Bisley, and can compete at the United Hospital Prize Meeting. There are now three Inter-Hospital Cups for teams—the Bisley, the Armitage, and the Lloyd—and one individual—the Arnold— which is competed for at the Annual Meeting. Last year the Hospital held both the Armitage and Bisley Cups, but this year the team were less successful, finishing second in all three competitions.

Altogether, targets were available at Bisley on six Wednesdays in May and June of this year, and one away match was shot. Sweepstakes, under handicap, are arranged on each day.

There is an annual Guy's Hospital Prize Meeting, which includes a scratch handicap and aggregate competitions, five in all, the Scratch Challenge Cup presented by Dr. Pitt being the most important prize.

Vouchers entitling men to cheap return fares to Brookwood—the Station for Bisley Camp—are issued, and the London and Middlesex Counties' Rifle Association are kind enough to allow us the use of their hut on all hospital shooting days. The Association keeps a rifle which is available for the use of any man not possessing one of his own.

During the past year efforts have been made to start a Miniature Rifle Club in connection with the Association,

and it is hoped that permission may be granted for a range to be fitted up in the Hospital itself.

All men who have ever done any shooting at School, University, etc., are asked to give their names and averages to the Hon. Sec., or to some member of the Committee, before next May. Several members of this year's team will not be available for next season, and a good reserve of reliable shots is essential if we are to win back the Cups.

The Annual General Meeting will be held somewhere about the end of October, and it is hoped that all men interested in shooting will endeavour to attend. Notices as to date, time, and place, will be posted in the Smoking-room, and on the board in the colonnade.

The Golfing Society.—President: G. Newton Pitt, M.D. Vice-Presidents: H. C. Cameron, M.B., H. L. Eason, M.D., M.S., C. H. Fagge, M.S., F.R.C.S., J. Fawcett, M.D., Rev. A. Lethbridge, A. W. Ormond, F.R.C.S., F. J. Steward, M.S., F.R.C.S. Committee: R. Creasy, R. Curle, M. M. Earle, H. V. Gibbons, W. S. Kidd, F. Morres, F. D. Saner. Hon. Secretary and Treasurer: L. Bromley.

This society was formed in May, 1908, for the purpose of promoting Inter-Hospital Golf, and also to provide local interest by means of competitions, matches, etc. The society is affiliated to the Clubs' Union, and therefore all members of the Union are members of the society. Matches are arranged with other hospitals and clubs. A handicap tournament will be held each winter and summer session. A Monthly Medal Handicap Competition is held on the fourth Wednesday of each month. Cards and information can be obtained from the Secretary or any of the Committee.

An arrangement has been made by which members of the above society may play on five days in the week—viz., Monday to Friday—at the Ilford Golf Club, on payment of an annual subscription of £1 1s., without entrance fee. Such members may play on Saturdays, Sundays and Bank Holidays at the rate of 2s. 6d. a day.

This arrangement holds from October 1st, 1908, when the Ilford Club year commences; until then, members may play over the links on payment of a green fee of one shilling a round. The links are situated about ten minutes' walk from Ilford Station.

Those wishing to pay the annual subscription should communicate with the Secretary of the Ilford Golf Club.

The Hockey Club.—President: F. J. Steward, Esq., M.S., F.R.C.S. Vice-Presidents: A. W. Ormond, Esq., F.R.C.S., C. H. Fagge, Esq., M.S., F.R.C.S. Captain: G. W. Dryland. Vice-Captain: G. Y. Thomson. Hon. Sec. and Treasurer: W. T. Clarke.

Last season we were again unable to procure a ground. A few matches were played away, and in most of them we were successful.

In the Cup Ties we beat Middlesex Hospital by 3–2, St. Thomas's by 4–1, and in the final, after a strenuous game, we managed to beat St. Bartholomew's by 2–1, thus securing possession of the Cup for the third time in the five years in which it has been in official existence.

A. H. Birks and L. Bromley considerably strengthened our forward line: they have both been awarded their Half-Blues.

It would be a great help if anyone who is interested in hockey would look out for a ground, and let us know about it, as at present we have been unable to obtain a ground. Only a few fixtures have been arranged, so that if anyone hears of teams wanting mid-week matches, will they please communicate with us.

All communications should be made to G. W. Dryland, W. T. Clarke, or G. Y. Thomson. There will be a hockey meeting, notice of which will be put up in the smoking room. All freshmen should make themselves and their qualifications known.

The Swimming Club.—The Guy's Hospital Swimming Club was formed in 1892, under the presidency of Mr. A. D. Fripp. The Inter-hospital Water Polo Cup Competition was instituted in the same year, and Guy's have entered for the Cup every season since, winning the competition five times, and halving it after three drawn matches with St. Thomas's in 1905.

The following are the Officers of the Club:—President: Sir Alfred Fripp, K.C.V.O. Vice-Presidents: C. H. Fagge, Esq., M.S., R. P. Rowlands, Esq., M.S., F. S. Steward, Esq., M.S., J. Lewin Payne, Esq., L.D.S., and Graham Marshall, Esq., L.D.S. Captain: W. T. Clarke. Hon. Secretary and Treasurer: G. B. Pritchard.

Besides the Cup Competition, there is an annual Inter-hospital Team Race Competition. Last year we were successful in winning both the Cups. We beat London by eleven goals to nil in the Water Polo, and Charing Cross by about five yards in the Team Race.

An entertainment is held every year in June, consisting of races, diving, costume race, etc., etc.

Students, by the courtesy of the Matron, are allowed to use the swimming bath in the Nurses' Home on alternate week-days and Sundays. Opportunities for practice, both at polo and racing, are thus abundant.

The Annual Meeting, which all freshmen interested in swimming should attend, will be held early in the new year. Notice will be given on the board in the colonnade.

The Pupils' Physical Society.—Hon. President: Sir Samuel Wilks, Bart., M.D., LL.D., F.R.C.S. Hon. Vice-Presidents: J. F. Goodhart, M.D., LL.D.; Sir Henry Howse, M.S.; P. H. Pye-Smith, M.D., F.R.S.; G. H. Savage, M.D. Hon. Secretaries: G. W. Nicholson, M.D.; W. M. Mollison, M.C., F.R.C.S.

This flourishing society was founded in 1830, on the plan of the old Physical Society, which existed during the latter part of the eighteenth century at Guy's Hospital.

At the Pupils' Physical Society, which meets each fortnight on alternate Wednesday and Saturday evenings, a paper on some subject, not necessarily of medical

interest, may be read by any member, to be followed by a discussion. "Clinical and Pathological Evenings" are devoted to the exhibition and discussion of interesting cases or specimens which may be shown by any member. Members are reminded that in connection with the society the following prizes are offered for competition: The Treasurer's Prize of £5 is given annually, and the subject of the Essay for the ensuing session is to be announced shortly. The society offers a prize of £10 for the best paper read during the session; a prize of £5 to the member who distinguishes himself most in the discussions; and a prize of £5 to the member who exhibits the best specimens of scientific interest during the session.

THE DENTAL SOCIETY.—President: J. E. Spiller, Esq., L.D.S. Hon. Secretary and Treasurer: F. Bocquet Bull.

The object of this Society, which was founded in 1894, is the promotion of interest in Dental subjects, and the discussion of Dental topics. Papers are read before the Society each month, and a prize (value £5) is awarded for the best paper read before the Society during the session. Casual communications are invited at all meetings, and a prize (value £1) is awarded at the end of the session for the best set produced.

One meeting during the session is set apart for the examination and discussion of cases of special interest, the patients being brought up for examination.

The meetings are held every month during the winter session in the Physics Lecture Theatre, adjoining the Conservation Room. The meetings take place at 4 p.m. on the second Friday in the month, and tea is served before the meetings in the Physics Laboratory (adjoining the Physics Theatre) for members attending the meetings. New men are strongly urged to attend and take part in these meetings, which, in the past, have proved instructive as well as interesting.

THE DEBATING SOCIETY.—President: G. H. Savage, M.D., F.R.C.P. Vice-Presidents: J. Fawcett, M.D., E. I. Spriggs, M.D., A. W. Ormond, F.R.C.S., M. S. Pembrey, M.A., M.D., H. C. C. Mann, M.D., A. R. Thompson, F.R.C.S. Hon. Secretaries: A. Neville Cox, F. Cook, and a Committee of six students.

The Society has now reached its seventeenth year, having been founded in 1892, with Dr. Pavy, F.R.S., as first chairman. It has always been one of the most popular of the constituent societies. The subjects for debate are chosen so as to afford equal interest to both senior and junior men. There are, during the session, five ordinary meetings, a "Ladies' Night," and an annual Dinner. The meetings are held on one Saturday evening each month in the Smoking-room, and the subject for debate is advertised a full week before each meeting. The first meeting will be held on October 10th, at 8 p.m., when Dr. Savage will take the chair.

THE GUY'S HOSPITAL GAZETTE.—The GAZETTE is published on alternate Saturdays throughout the year, and can be obtained from the Librarian. Each member of the Clubs' Union is entitled to a copy of each issue throughout the year; after five years, when he has become a life member of the Union, he is required to pay an annual subscription to the GAZETTE (and Reports) if he desire to continue taking them.

All Guy's men are invited to contribute to the GAZETTE, and all articles, accompanied by the sender's name, not necessarily for publication, should be placed in the Editor's box in the colonnade at least by the Wednesday preceding the next issue.

THE GUY'S HOSPITAL REPORTS.—Edited by F. J. Steward, M.S., and Herbert French, M.A., M.D.

The Reports are published annually, and each subscriber to the Clubs' Union is entitled to a copy, which he may obtain in the Wills Library from the Librarian. Each volume contains papers by members of the Staff of the Hospital and Medical School upon original work done in the Hospital during the preceding year; it also contains a list of the gentlemen who have been educated at Guy's Hospital, with the appointments they have held during the year, the examinations they have passed, and the prizes and honours they have won. The first volume appeared in 1836; copies of the earlier volumes can be obtained from the Editors. The value of this annual publication is obvious, and every Guy's man is proud of the original papers of its Staff, from those of Addison, Bright, and Hodgkin to those of the present day.

THE CHRISTIAN UNION.—The Christian Union was started in 1849 by Dr. Habershon and Dr. Golding-Bird, who held meetings in their houses for students of Guy's and St. Thomas's Hospitals. Since that time similar institutions have been formed in all the London hospitals.

The Christian Union is now a part of the Student Christian Movement of Great Britain, which, again, is part of a world-wide brotherhood of Christian students, known as the World's Student Christian Federation. This movement was started in 1893, as an outgrowth of the Student Volunteer Missionary Union, which was formed in the previous year through the interest awakened by visits paid to several Universities and Colleges by Messrs. Stanley Smith and C. T. Studd, prior to their departure as missionaries to China, and also by the visits of Messrs. Forman and Wilder, who told of the growth of missionary enthusiasm in the colleges of America. At that time religious societies among students existed in only twenty British Colleges; to-day there are Christian Unions in 121 Colleges and Universities, with a membership of 4,500. The World's Student Christian Federation has a membership of over 103,000 in 40 different countries. Every year a summer camp conference is held at Conishead, with an attendance of about 600. During the Winter Term, conferences are held in London, and the last two years large gatherings of students have been held in the Mansion House and Guildhall.

The objects of the Christian Union are to lead students to become disciples of Jesus Christ, and to promote their spiritual life by regular meetings for prayer and Bible study.

The Missionary Society holds meetings every month.

During the Winter term it has been arranged to hold a monthly meeting, at which an address will be given. Every week meetings will be held for conversational Bible study. Prayer meetings are held every day. The speakers and time of meeting will be announced later. Hon. Secs., F. D. Berry and H. A. Sanford.

The Students' Club.—Committee till 1909 (March). President: W. Hale White, M.D., Treasurer: John Fawcett, M.D. Hon. Secretary: H. C. Cameron, M.B., Hon. Assistant Secretary: G. Hamilton, M.B.; and a committee of eight.

The above named manage the affairs of the Club, a full account of which will be found in the Clubs' Union Blue Book.

Guy's Musical Society.

President: Lauriston E. Shaw, Esq., M.D. Conductor: Mr. Henry Taylor. Orchestral Section Conductor: H. L. Eason, Esq., M.D. Representative: W. M. Mollison, Esq., F.R.C.S. Secretary: D. A. Mitchell.

In calling the attention of all freshmen and others to this Society, we feel a certain confidence in the result, inasmuch as the Society is practically unique among London hospitals. It is now in its fourteenth season, and it is the conductor's proud boast that at none of its concerts has it had to record a failure. In order, however, to maintain such a clean sheet it is highly important to secure the co-operation of all, and especially to recruit from the ranks of "freshers" men to fill the places of those who have left. There is no voice test and no subscription. No one, however humble his powers, need hesitate, at any rate, to make a trial of them, and for the encouragement of such it may be said that there are many men now who gratefully acknowledge that their taste for and power of choral work has been engendered and fostered by the Musical Society. With a view to giving some idea of the work done by the Society, all men interested are invited to attend at the first combined practice to either listen or take part. This practice will be held on Friday, October 9th, at 8 p.m.

Two concerts are given during the season. Practices are held every Friday at 5 p.m., and on alternate Fridays at 8 p.m. These last for one hour, and due notice of them, together with other information, will be found in the notice case of the Society (opposite Astley Cooper door). The Secretary and other officers of the Society will be glad to hear from intending members, and to give them any other information they may desire.

Guy's Physiological Society.

President: Dr. Pembrey.

This is one of the most popular of the Hospital societies, as its ever-increasing membership testifies. Meetings are held once a fortnight, at each of which a paper is followed by a discussion, informal and generally heated, thus offering not only instruction in physiology, but also an excellent opportunity of founding those powers of eloquence so essential to every medical man. The society possesses a library of scientific books. A prize is offered by Dr. Pembrey for the best paper read during the session. The annual subscription is half-a-crown. Whilst the society affords special advantages to men reading for their second or equivalent examination, most of the papers are of general scientific interest. The annual general meeting, for the election of officers, etc., will be held early in October. The date will be announced later. New men are invited to attend at this meeting.

Reviews.

The price of books submitted for review should in every case be stated.

Proceedings of the Royal Society of Medicine. Vol. I., No. 9. July. (Messrs. Longmans, Green & Co.) 7s. 6d. net.

The July number of the Proceedings contains, amongst other interesting things, a paper on the tone of cardiac muscle, by Dr. A. M. Gossage, in which the author manfully tackles a difficult problem. His views as to the action of digitalis—a preponderant local action—were discussed fully by the members present.

The neurological section contains an unusual number of good cases, whilst students of dermatology will find much to attract their interest in the latter section.

Dr. Teacher gave a demonstration of an extremely young ovum—estimated at 13–14 days after fertilisation—before the obstetrical section. Before the same body, Dr. Haultain described a new method of treating chronic inversion. The technique of his operation is given in full. The discussion which followed showed that most of the members have great faith in the Aveling repositor, and considered that treatment by abdominal incision was, in most cases, unnecessary. Dr. Haultain had not much faith in the repositor, and preferred direct operative measures. Dr. Blair Bell read a paper on menstruation and its relationship to the calcium metabolism. He concludes, after much interesting work, that menstruation is dependent upon the calcium metabolism in all its ramifications.

In the surgical section, Mr. Spencer describes the reduction of an old subcoracoid dislocation through a posterior inter-muscular incision. It should receive much attention, as it no doubt marks a great advance in the treatment of this troublesome condition. Another paper on the treatment of fractures of the humerus is well worth reading. The general production is up to its usual excellent standard.

Clinical Lectures on Neurasthenia. By Thomas Dixon Savill, M.D., London. Fourth edition. (Henry J. Glaisher.) Price 7s. 6d. net.

That this volume of lectures has in less than ten years reached a fourth edition serves to indicate its popularity

and utility. The different forms of the neurasthenic state are well and clearly described, and are illustrated by well-chosen examples from the author's practice. Especially helpful to those whose practical experience of such cases is small, are the chapters upon the diagnosis of neurasthenia. The differential diagnosis between neurasthenia, hysteria, hypochondriasis, and melancholia is well and clearly set forth. The means of treatment which are at the disposal of the physician are enumerated and described, and in a special chapter proper stress is laid upon the importance of the psychic treatment of such disorders. Apparently this chapter had been added, and appears for the first time in this edition. Without it the book would be deprived of much of its value.

In the chapters upon the etiology and pathology of neurasthenia, the author is upon more debatable ground. He is emphatic that, in the majority of cases, the accompanying dyspepsia is the cause of the neurasthenia, and not a symptom of it, and he has been at pains to tabulate his cases from this point of view. In the majority he has found that the dyspeptic symptoms preceded the neurasthenia. He goes further, and maintains that he is strengthened in his belief, because medicine directed to relieve the dyspepsia will more often cure neurasthenia than drugs which act upon the nervous system. On the whole we think that the chapter upon psycho-therapy is the best in the book.

Heredity. By J. Arthur Thomson, M.A., Regius Professor of Natural History in the University of Aberdeen. (Published by John Murray.) Price 9s. net.

This is the latest volume of the Progressive Science Series. It is an admirably written exposition of the principles of the science which deals with heredity, inheritance, evolution, and variation. Much prominence is given to three kinds of conclusions—those reached by the microscopic study of the germ-cells, those reached by the application of statistical methods, and those reached through experiment, and, as the author quaintly remarks in his preface, the new facts are of especial interest to medical practitioners, to educationists, including clergymen, to social reformers, and to actual or prospective parents.

To medical men the book is certainly bound to prove of interest, so long as the laws of heredity in disease remain to us dark and enigmatical. To those who are familiar with the writings of Darwin, it will be of interest, because it defines very clearly the progress which has been made since Darwin's time, and tells how often his conclusions, even his conjectures, hazarded upon insufficient data, have been verified. The book is illustrated by a large number of coloured plates and diagrams, which, with the author's charming and easy style, make pleasant reading of an abstruse subject.

Appointments.

Naval and Military.

Surgeon F. G. GOBLE, R.N., has been appointed to the *Minerva*, and Surgeon F. M. V. SMITH, R.N., to the *Vivid*, for disposal.

Lieutenant G. B. F. CHURCHILL, R.A.M.C., is promoted to be Captain.

Surgeon-General F. W. TREVOR, C.B., M.B., Army Medical Service, has been appointed Principal Medical Officer, H.M. Forces in India, from 22nd July.

Captain T. C. LUCAS, M.B., R.A.M.C., has been appointed to act as Surgeon on the Personal Staff of H.E. Sir George Sydenham Clarke, Governor of Bombay.

G. E. MALCOMSON, M.D., I.M.S., has been appointed a Specialist, Prevention of Medicine, Brigade Laboratory, Kamptee.

Territorial Forces.

To be Major—Surgeon-Major J. A. RIGBY, M.D.

To be Captains—W. H. BRAILEY, M.B.; L. A. PARRY, M.D., F.R.C.S.; A. M. DALDY, M.D., F.R.C.S.; E. B. DOWSET.

From the Gazette's Special Pathologist.

W. L. W. M., HUDDERSFIELD.—This piece of cervix uteri is hard and fibrous from chronic hyperplasia. It is covered by normal squamous epithelium, shows no glands, and contains no malignant growth.

A., CHADWELL HEATH.—No tubercle bacilli are detected in this specimen of sputum, which is comparatively non-purulent in character.

PATHOLOGIST.

Marriages.

CAWSTON—LINDSAY.—On September 3rd, at the Parish Church, Wantage, A. E. Cawston, M.R.C.S., L.R.C.P. Lond., to Esther Muriel, younger daughter of the Rev. John Lindsay, Wantage.

DAVIES-COLLEY—CROSBY-JONES.—On September 9th, at St. Mary's, Bryanston Square, by the Rev. R. C. Turner, M.A., cousin of the bridegroom, Robert Davies-Colley, M.A., B.C. Camb., F.R.C.S., of Guy's Hospital and Borough, Pulborough, Sussex, younger son of the late J. N. C. Davies-Colley, Esq., M.A., M.C. Camb., F.R.C.S., sometime Surgeon of Guy's Hospital, and grandson of the late Thomas Turner, M.A. Camb., sometime Treasurer of Guy's Hospital, to Emily, eldest daughter of A. Crosby-Jones, Esq., M.R.C.S., Chatham.

HUMPHRY—GRIFFIN.—On September 2nd, at St. John's Church, Crowborough, Lawrence Humphry, Captain, R.A.M.C., to Phyllis, elder daughter of Mr. and Mrs. Watson Griffin, of Beacon Court, Crowborough.

OMMANNEY—HART.—On September 9th, at St. James's Church, Kidbrook, Blackheath, by the Rev. Canon Marshall, B.A., assisted by the Rev. J. Morris, M.A., Rector of the Parish, Captain Francis Montagu Maxwell Ommanney, R.A.M.C., son of Col. E. L. Ommanney, C.S.I., and Mrs. Ommanney, of Kidbrook, to Annie Avery, only daughter of Mr. and Mrs. Cheney Hart, of Kidbrook, Blackheath, S.E.

Death.

BROWN.—On the 12th September, at Carlton House, Bell Lane, Gloucester, Walter Brown, M.D.

ED.—L. M.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

October.

Sat. 3. G.H.R.F.C. I. v. London Devonians (Home).
II. v. African Banks.
III. v. R.M.A. Woolwich.
G.H.A.F.C. I. Trial Game.

Thur. 8. Messrs. Symonds' and Steward's Take-in; Messrs. Sanford and Ewing.
Pupils' Physical Society, Opening Night. Dinner, 6.25 p.m. Lecture by Sir Douglas Powell, 8.15 p.m. Exhibition in Museum after.

Sat. 10. G.H.R.F.C. I. v. Catford (Away).
II. v. Catford (Home).
G.H.A.F.C. I. Surrey Senior Cup Tie.
II. Surrey Junior Cup Tie.

Wed. 14. G.H.A.F.C. I. v. Emeriti (Home).

Thur. 15. Messrs. Lane and Fagge's Take-in; Mr. Dryland.

Sat. 17. G.H.R.F.C. I. v. Rosslyn Park (Away).
II. v. Old Blues (Home).
III. v. St. Paul's School II. (Away)
G.H.A.F.C. I. v. London Devonians (Home).

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated.*

Passim.

THIS time of the year, which is associated with the coming of so many new names and faces, is also associated with the loss of some which are familiar. As well as the off-going residents, we have lost this month two of our teaching staff, who, as medical and surgical registrars respectively, have been familiar spirits about the hospital during the last two years. Dr. Mann, who entered the hospital in 1897, and Mr. Hamilton, who entered a year later, are both London University men. Mr. Hamilton, after qualifying, acted as H.-P. to Dr. Taylor, and then received the appointment of Surgical Registrar on the resignation of Mr. Greeves. Dr. Mann achieved the rare distinction of acting in turn as H.-P. and H.-S., following which he obtained the degree of M.D. Lond., and the Membership of the Royal College of Physicians. As a teacher in the medical wards, the Out-patient Department and the Post-Mortem Room he was eminently successful. In another field, he has acted for some time as the able and energetic secretary of the Clubs' Union, and the latest fruit of his activities in this direction has been the improved Clubs' Union Blue Book. Both Mr. Hamilton and Dr. Mann—as students, residents and

registrars—have been extremely popular. As teachers they spared no endeavours to help men as much as they could. Many will remember with pleasure those extra demonstrations which Dr. Mann gave before examinations. Not a brief half-hour class, but a painstaking demonstration at which every man felt that he was getting exactly what he wanted, and felt also that the teacher was striving to ensure success for everyone. We trust that both will have prosperous and happy careers, and that Guy's will see them often.

It does not seem to be generally known that a special day is now set aside for Orthopædic cases. Mr. Rowlands, who is in charge of this department, takes this branch of Out-patients on Tuesday mornings at 9.30. It seems to us, judging from the number of cases which find their way into the ordinary Surgical Out-patients, that it would facilitate matters if the time and day for receiving Orthopædic cases were recorded on the White Card and added to the list which is on the board near the Main Gate.

In time to come, maybe, the teaching of this branch of Surgery will rise to the level it has attained on the Continent. It is generally recognised, unfortunately, that much could be done to increase the value of this teaching, and we venture to think that, with the material at hand and a better recognition of a definite Out-patient day, Guy's may be some day the proud possessor of a department similar to the new one at St. Bartholomew's.

The Residents' Going-off Dinner was held last Tuesday, and was in every way an enjoyable function, the old order of things being reverted to. At this season of the year it is also a most important one, for it involves the election of a president to fill that office during the three months in the year when, as the newly-elected president was bold enough to say, the honour is certainly an onerous one. To the universally popular ex-president, Mr. Earle, and the vice-president, Mr. Stebbing, and the other off-going Residents, Messrs. Flower, Watson and Young, we can only say that we hope their success in the big world outside Guy's may soon compensate their sorrow at leaving our little world. But they will be sadly missed at the familiar table. Mr. Dryland was elected the new president, and Mr. Palmer the new vice-president. The songs contributed by Messrs. Peall, Davies, Palmer, Johnston, Catto and Croft added much to the success of the dinner.

This is truly an age of abbreviations, and it must have given Mr. Golding-Bird no little pleasure to have read the censure which Mr. Fordham, the magistrate, passed on the use of the letters L.C.C. by a witness. Most of us at some time or other have heard our ex-senior surgeon deliver a tirade against the trite C.O.A., H.P.D., etc., of the ward reports; nevertheless one anonymous spirit amongst us deems that, owing to the crowded present-day curriculum, all time-saving devices should be employed, and he has forwarded us what he terms a ward-clerk's vade mecum. It is produced on another page, but we entreat ward-clerks not to take him too seriously.

The lay journals still pursue their admirable course of keeping the public *au fait* with recent medical discoveries The two latest are delightfully quaint: the "newly-discovered" cure for cholera—the injection into the axillæ of salt solution, and a cabled message from France relating a marvellous operation—the treatment of fractures by inserting screws between the fragments. Probably these ardent correspondents cull their medical knowledge from the nauseating quack advertisements that fill the columns of their journals.

Once again we venture to draw our readers' attention to the Physical Society's first dinner and meeting, to be held next Thursday evening. Old Guy's men are cordially invited, and we are certain the secretaries would be pleased if these men would avail themselves of this evening for an annual reunion. Mr. Cosmo Bonsor will preside at the dinner, whilst at the meeting Sir Douglas Powell's address, "A just Perspective in Medicine," is certain to be full of interest. Freshmen should make a special point of attending this evening. Tickets for the dinner, 3s. 6d., may be obtained from the secretaries, any of the

presidents, or on application at the desk in the dining hall.

We hear that the German class, which Herr A. G. Haltenhoff has been holding at Guy's for some years, will begin again early in October. The class has been well attended, showing that an opportunity to study German for the purpose of reading German medical works, or for travelling, is well appreciated. Full details may be obtained on application to the Medical School Office.

The opening meeting of the Debating Society will be held in the College Smoking Room on Saturday next, October 10th. Dr. Savage, the President of the Society, will take the chair at 8 p.m. Mr. N. A. D. Sharp will propose, "That in the opinion of this house the parliamentary suffrage should be extended to women on the same terms as it is possessed by men." Mr. D. Reynolds will oppose the motion. The subject for debate has certainly no claims to novelty, and perhaps has every claim to banality, but it was felt desirable that the question of "votes for women" should be definitely settled by our Society. The Secretaries particularly wish to remind all freshmen who are members of the Clubs' Union that they are also members of the Debating Society, and hope that as many new men as possible will turn up at the opening meeting, either to talk and vote, or to listen and vote. Any member may introduce a visitor, who may take part in the discussion, and may vote on the motion.

It is our sad duty to have to report the deaths of three old Guy's men—Dr. Bushell, C.M.G., Dr. Clague, and Dr. W. H. Cole. Stephen Wootton Bushell was a Guy's student in the sixties, and gained for himself and his hospital a brilliant series of examination successes at London University, after which he held the posts of House Surgeon (1866) here, and Resident Medical Officer at Bethlem Hospital. He afterwards received the post of Physician to the British Legation in Pekin, and he continued in that capacity up to 1900, when he retired owing to ill-health. During all those years in the East, in addition to his professional duties, Dr. Bushell devoted much of his attention to all things connected with Chinese art, especially ceramic and porcelain, and he embodied the results of these researches in a number of works which he published during his retirement in England. He was also a member of various learned societies, and was made a C.M.G. in 1897.

Dr. John Clague, who died suddenly at his residence at Castletown, Isle of Man, on August 23rd, entered the hospital in 1868. In 1870, he was First Prizeman and Exhibitioner. After obtaining the L.S.A. in 1872, and the diplomas of M.R.C.S., L.R.C.P. in 1873, he returned to the Isle of Man, and began to build up a practice. He received numerous public appointments, including the post of Surgeon to the Household of the Lieutenant-Governor of the Island, and he was largely occupied as a consultant. As a hobby he took a keen interest in the Manx language and folklore. He was honoured and esteemed throughout life by his fellow-practitioners and the public, and his death means a very real loss to his native isle.

Dr. W. H. Cole, whom some men still up here may remember, died at sea of dysentery, on the 23rd September. He had been surgeon to the P. and O. steamship *Malta* for the last three voyages, and was on his return home when he was taken ill and, after a brief illness, died when the vessel was off Singapore. He entered in 1896, and qualified in 1903, taking the Conjoint Diploma. Throughout his days here he was known as a hard-working and conscientious student, and his early demise, at the age of 30, has cut short a promising career. We extend to his relatives our most sincere condolence.

Papers by Guy's Men.

Two Cases of Pneumococcal Peritonitis in Children. By W. H. Bowen, M.S. Lond., F.R.C.S.—*British Medical Journal*, 26th September, 1908.

A New Synthesis of Apocynin, and The Constituents of Canadian Hemp. Part I., Apocynin. By Horace Finnemore, B.Sc.—*Transactions of the Chemical Society*, 1908. Vol. 93.

Concerning Blood Cultures and other matters Bacteriological.

By A. N. LEEMING, B.S.

It is now several years since cultivations of the blood for organisms were first made at Guy's. What are now used as Widal tubes were employed, and capillary blood from the lobule of the ear was collected. Thus only a small quantity of blood was cultivated, and it is not surprising that organisms were rarely found by these means. Now that blood-culture has become a therapeutic as well as a diagnostic measure, it is worth while to be acquainted with its present technique.

The median cephalic vein is usually chosen from which to withdraw blood, and a sterile all-glass syringe is best for the purpose. After rendering the skin over this vein as sterile as possible with lysol and ether, a tourniquet is tied round the upper arm just sufficiently tightly to obstruct the venous, but not the arterial flow. This renders the vein larger and more readily punctured. 1 c.c. of 20 per cent. sodium citrate solution must be sucked into the syringe to prevent the blood clotting, and all air should be expelled from the latter; the skin at the *side* of the vein is perforated, and the vein is entered from the side. When the vein is punctured—if the syringe acts well—the pressure of the venous blood will cause it to fill the syringe. Between 5 and 10 c.c. of blood should be withdrawn in this way. Then remove the tourniquet and cover the wound with Mead's strapping; and straightway inoculate each of six tubes of sterile bouillon (broth) with 1 c.c. of blood direct from the syringe. Incubate the six tubes for seventy-two hours at 37° C. and examine hanging drops every twenty-four hours.

Occasionally a growth of the staphylococcus albus or xerosis bacillus will come up—these are common skin saprophytes and indicate contamination. The commonest organism to be cultivated from the blood is the streptococcus longus; but other organisms are found, though much less commonly, *e.g.*, pneumococcus, gonococcus, bacillus coli, and bacillus typhosus. Sometimes, when one attempt is unsuccessful, it is wise to select a time when the patient's temperature is higher than usual, often between 6 and 10 p.m., for it appears that with a higher temperature there are more organisms circulating in the blood.

It may be asked whether the finding of organisms in the blood indicates a hopeless prognosis. By no means; for it is well known that the pneumococcus is extremely commonly found in the blood in cases of pneumonia, and the bacillus typhosus in the blood of cases suffering from typhoid fever—yet in both instances the patients usually recover; and that streptococci can be found in patients suffering from malignant endocarditis, and yet the patient may so far recover as to reach a convalescent home, is exemplified by a case recently in the wards. Six attempts to obtain the organism from the blood were made; eventually a streptococcus longus was cultivated and a vaccine prepared. The patient's temperature responded to injection of small doses, with the excellent result before mentioned. But, notwithstanding, the presence of streptococci in the blood must be regarded as of most serious import, though not hopeless.

The above case indicates the value of blood culture as a means of obtaining the patient's organism for vaccination purposes; and such a measure should never be omitted when septicæmia is suspected, and no other means of obtaining the invading organism is afforded.

* * * *

Cases of multiple arthritis, whenever seen, should suggest some primary infections away from the joints themselves. Although the number of cases in which the gonococcus in the urethra is the cause of multiple arthritis is extremely large, there is another group of cases which there is danger of overlooking. The examination of the gums for pyorrhœa alveolaris is a very simple procedure, and should never be omitted—for occasionally this disease appears to be the primary focus of absorption, producing a multiple septic arthritis. The treatment of the condition is a thorough "scaling" of the teeth by a dentist, and the preparation of a vaccine. The organisms most usually responsible for the disease are the micrococcus catarrhalis and the streptococcus brevis. Occasionally one or other of these organisms is obtained in pure culture. It is usually found that the catarrhalis vaccine produces the best results. This latter organism is a normal inhabitant of the respiratory passages, and is usually accredited as the organism of the common cold. It is a gram-negative coccus which occurs in pairs and dense clusters, growing readily on the ordinary media at the usual temperatures, and which differs from the gonococcus and the meningococcus, which are also gram-negative diplococci, in that it will not ferment media containing either glucose, galactose, maltose or saccharose. The gonococcus ferments the first

two of these—the meningococcus all but the last of the four.

Occasionally suppuration in the accessory nasal sinuses will produce, owing to its chronicity, a similar multiple arthritis; the presence of this disease should be suspected if there is a discharge from the nose, or if the patient complains of a constant cold. The organisms commonly associated with this disease are various staphylococci and the micrococcus catarrhalis; and vaccine treatment has yielded good results in this disease as for pyorrhœa.

In Lighter Vein.

DICTIONARY OF HOSPITAL ABBREVIATIONS,

OR, THE WARD CLERK'S VADE MECUM.

Designed also for the use of extension dressers, governors, residents, nurses, and others connected with the hospital.

A.D.F.	...	A ducal favourite.
A.H.S.	...	An honorary sinecure!
A.P.B.	...	A (per)cussing blighter.
A.R.T.	...	A real Tartar.
B.C.C.	...	Blesses chronic constipation.
B.I.D.	...	Bell's immediate due.
B.P.	...	Beddard's paradise.
C.O.D.	...	Cured or dead.
G.H.P.	...	Good harmless pamphlet.
G.O.K.	...	(?) Gynæcological or (?) kidding.
G.P.	...	Glorious prevaricator.
G.P.I.	...	Giddy past indicated.
H.B.F.	...	Heals by faith.
H.O.P.	...	Hades or Paradise (?).
H.P.	...	Helps pathologists.
H.S.	...	Hinders sister.
I.A.P.	...	Insects are prospering.
K.L.B.	...	Keeps lively bacteriologists.
L.S.A.	...	Last step available.
O.P.O.	...	Orders "P.O."
P.M.	...	Past mending. (Otherwise—Physician's mistake).
P.O.	...	Pass on.
R.S.O.	...	Reposeful slumber occasionally.
R.I.P.	...	Rest in pieces (*i.e.*, Remain in pickle).
R.M.O.B.	...	*Respectable* man or boy.
S.O.S.	...	Sister's opinion settles.
T.T.	...	Tuesday's tribe.

X. Y. Z.

The British Society for the Study of Orthodontia.

THE British Society for the Study of Orthodontia has appointed a committee to ascertain what work has been done up to the present by way of ascertaining the proportions of the different types of normal dental arches, and applying this knowledge to the treatment of actual cases in practice. It is thought that just as human skulls are classified according to the cephalic index, which is based on the measurements of length and breadth, so the study of dental arches, based also on anthropological methods, might be of great service as a basis for the more serious study of Orthodontia. The Society is, therefore, anxious to ascertain whether any measurements of normal arches have been made with this object in view, and will be grateful for any references to papers which have been published on the subject in any language, or for the names of any who have been occupied in a research of this kind.

The committee would indicate the following as the points upon which they will be glad to have any specific information or statistics, either regarding the temporary or permanent arches:—

1. Relation of length of arch to breadth: What were the methods of measurement, and what points were taken to measure between?
2. Relation of size of teeth to size of arch: What method of determining this correlation was adopted?
3. Height of palate: Points of measurement used to determine this?

Any information bearing on this subject, or reference to papers, will be gratefully received by—G. G. CAMPION, 264, Oxford Road, Manchester; H. CHAPMAN, 20, Queen Anne Street, London, W.; J. E. SPILLER, 62, Worple Road, Wimbledon.

Guy's Hospital Medical School.

The following Entrance Scholarships and Certificates have been awarded:—

Senior Science Scholarship for University Students.—£50, Nathan Mutch, B.A., Emmanuel College, Cambridge; Certificate, H. W. Barber, B.A., Clare College, Cambridge.

Junior Science Scholarships.—£150, J. F. G. Richards, Preliminary Scientific (M.B.) Class, Guy's Hospital; £60, W. L. Webb, Preliminary Scientific (M.B.) Class, Guy's Hospital; Certificate, G. S. Miller, Preliminary Scientific (M.B.) Class, Guy's Hospital.

Entrance Scholarships in Arts.—£100, A. J. E. Smith, Rugby School; £50, H. W. Evans, Modern School, Bedford.

29th September, 1908.

Experiences of a Medical Motorist.

Nearly four years ago, when I had driven 2,000 or 3,000 miles, I ventured to write to the *Lancet* to advise —out of the depths of my own ignorance—all my fellow country G. P.'s to get motors.

My arguments were economy, speed, safety, reliability, and the luxury of more time at home.

Alas! I have since then driven 40,000 to 50,000 miles, and my rosy views are crumpling and fading.

I began with solid tyres, hoping to save the great expense and annoyance of punctures and tears. Before three months had passed, I had broken the record with five cracked axles and two broken driving hubs, a new steering gear, and a new expanding clutch. At considerable cost I had repairs done, new wheels made, and pneumatic tyres fitted; and now, on flint roads, I am resigned to a regular expenditure for new tyres every 3,000 or 4,000 miles, or about every quarter-day. My expanding clutch cost me a small fortune, as no agent could—or would—set it for more than a few journeys, and every few months it was reported to be burned up, and needing new fibre, etc.

The petrol I used disappeared at the rate of a gallon for every twelve to fifteen miles, and I still shiver at the outlay incurred for lubrication, spare nuts, split pins, etc., etc.

Of course, it was a "bad car," "badly treated," and to avoid "scrapping," I persuaded the makers to repair it for about one-third of the original cost, while I bought another car, of another make, of the same B.H.P., but seated for two instead of four passengers.

For 1,000 to 1,500 miles this was ideal; truly, the tyres bought on it wore out after 300 to 700 miles, and had to be replaced, but the car ran well and gave no trouble until the petrol tank cracked—a good split—and was exchanged by the makers for a new one.

Something, soon after, began to ail an axle, and while repairing that the agent found a "defective cylinder from a broken piston ring." This also was exchanged by the makers, only to be shortly after cracked and renewed—this time at my expense. Then the carburettor, a patent one for economy—18 to 20 miles to the gallon—went wrong with a plug of solder in the inlet pipe, and so on *ad infinitum*.

Meanwhile, Car No. 1 had been made better than new by the makers, and now, the proud possessor of a third and better machine, I am more contented, if less enthusiastic, than formerly. But I would advise beginners (*a*) That I have found the stable expenses of five horses and three carriages less than the cost of one motor. (*b*) That an automobile need not, and will not, be always ready day and night. (*c*) That, although pity for the tired horse disappears, care for the man, the radiator, and even the cylinder is just as pertinent in frosty weather. (*d*) That motoring, even for business, is a luxury, and, as such, must be paid for heavily.

Truly, the economy of fatigue and time is enormous. A fifty-mile journey with a horse will take at least six hours; with a motor two to three only. With a horse, time must be wasted, in gossip frequently, for the sake of the refreshment of both man and horse; with a motor, ten minutes will suffice to re-invigorate both. With a horse, the owner has no time for luncheon or tea; with a motor, he has three and a half to four hours to play with, or to enjoy at his home. With a horse, he may have an accident, running into two figures; with a motor, the two figures become three or four. With a horse, unless he is a fool, he is safe from the police; with a motor, he may be, at any time, hauled up, fined, and *execrated* for too rapid driving, for shaken out lamp, for a dust-covered number-plate, or some other tomfoolery, such as a frightened horseman, who, although perhaps not ten years old, has been entrusted with a large horse and cart, or a spirited pony. With a horse, he may have an angelic temper, but with a motor he will, in all probability, very soon rival

Διαβολος.

Sept. 24th, 1908.

Correspondence.

To the Editor of Guy's Hospital Gazette.

A Diagnosis Confirmed.

Dear Sir,—I have a patient, an old man, whom I informed, in answer to his inquiry, that he was suffering from *gastric catarrh*. Our vicar tells me that, going to see him a few days after, and asking him how he was, he got the following amusing account:—

"I have been very bad, but am better now. My chest was full of flame, and my breathing very bad. However, I was sitting by the fire the other evening when I had a dreadful cough, and brought up a lot of flame. I spit it into the fire and it blazed up, and then I knew that what the doctor said was true, and that my stomach was full of *gas tar*."

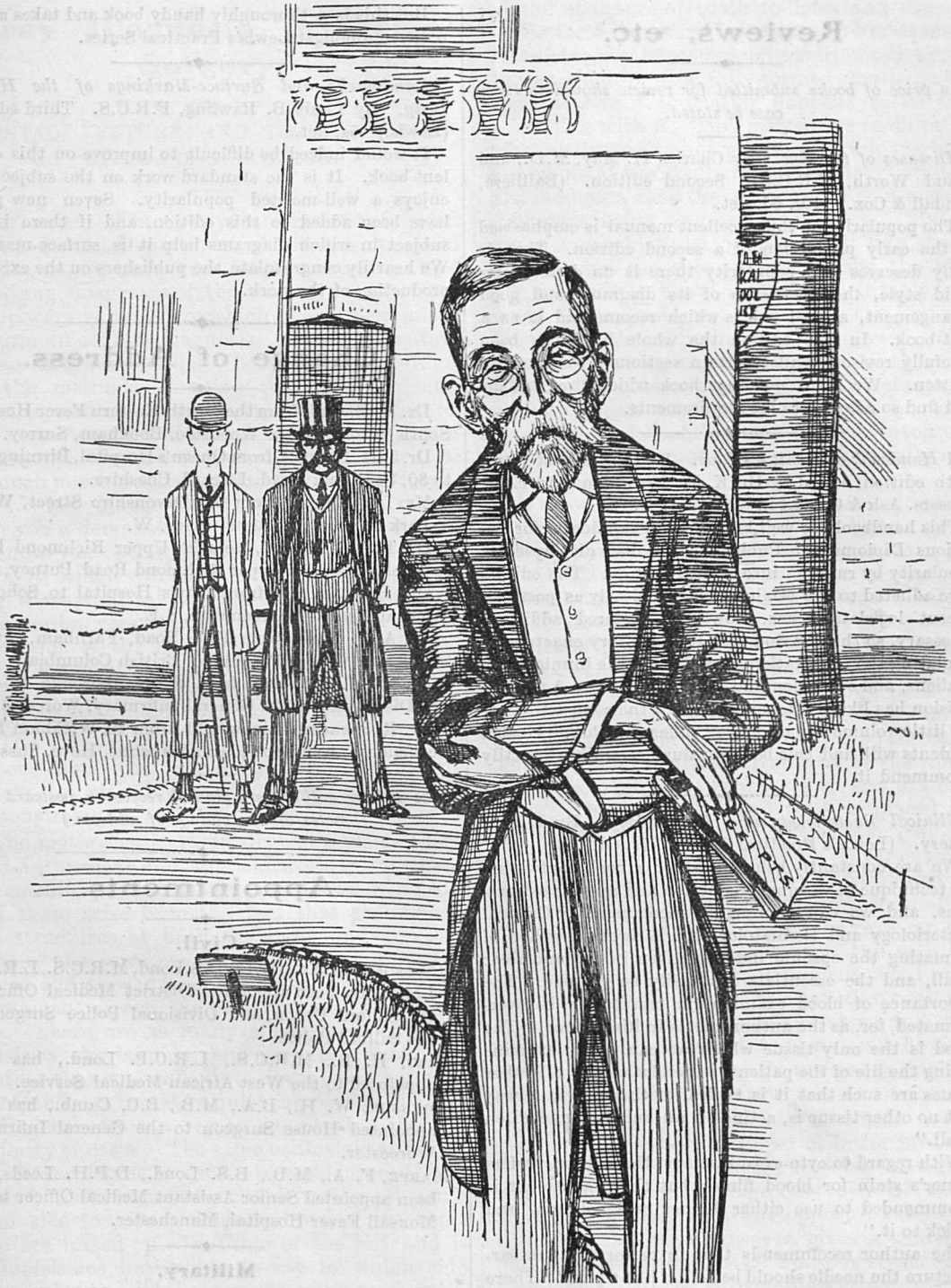
Bourton, Dorset. B. POPE BARTLETT.

Papers by Guy's Men.

A New Operation for Depressed Fracture of the Nose. By T. G. Ouston, F.R.C.S. Eng. (Illustrated.)—*British Medical Journal*, 26th September, 1908.

The Sanitation of Mines. By Frank Shufflebotham, M.A., M.B., B.C. Cantab.—*The Lancet*, 26th September, 1908.

Diffuse Painful Lipoma of the Foot. By A. H. Tubby, M.S. Lond., F.R.C.S.—*Ibid.*



AFTER THE TOUR OF INSPECTION.

Parent (or Guardian).—"Affable sort of feller, that; suppo-e he's the Dean we've heard so much about!"

Reviews, etc.

The price of books submitted for review should in every case be stated.

Diseases of the Eye. By Charles H. May, M.D., and Claud Worth, F.R.C.S. Second edition. (Baillière, Tindall & Cox.) 10s. 6d. net.

The popularity of this excellent manual is emphasised by the early production of a second edition. That it truly deserves this popularity there is no doubt. Its lucid style, the excellence of its diagrams and good arrangement, are all points which recommend it as a text-book. In this edition the whole book has been carefully revised, whilst certain sections have been re-written. We know no other book which the student will find so adapted to his requirements.

A Handbook of Sanitary Law. By Dr. Burnett Ham. Fifth edition, edited by Dr. K. W. Brown and Dr. Eyre. (Messrs. Ash & Co., Ltd.) 2s. 6d. net.

This handbook, so well known to all candidates for the various Diplomas of Public Health, has displayed its popularity by running into a fifth edition. The editors have adhered to the original form as closely as possible. Recent legislation has, however, rendered additions necessary, so that we find that the statutory enactments regulating the registration of midwives, the immigration of aliens, and education find a definite place. A general revision has likewise taken place, but the compactness of the little volume has in no way suffered. Public Health Students will find this book invaluable, and we heartily recommend it.

Clinical Bacteriology and Hæmatology. By D'Este Emery. (Lewis's Practical Series.) 7s. 6d. net.

We are constantly being asked for a book containing the technique of vaccine production and opsonic estimations, and we can thoroughly recommend "Clinical Bacteriology and Hæmatology." Wright's method of estimating the opsonic index is given in full and clear detail, and the essentials can easily be grasped. The importance of blood examination can hardly be over-estimated, for, as the author quotes in his preface, "The blood is the only tissue which we can easily examine during the life of the patient. Its relations to all other tissues are such that it is typical of them all in a way that no other tissue is, acting on all and being acted on by all."

With regard to cyto-examinations, the author prefers Jenner's stain for blood films; but the practitioner is recommended to use either Jenner or Leishman, and "stick to it."

The author recommends that in performing lumbar-puncture the needle should be held "like a pen." There may be different ways of holding a pen, but we consider that the *grasp* figured in the excellent photograph on the same page is more practical.

But this is a thoroughly handy book and takes a high position amongst Lewis's Practical Series.

Landmarks and Surface-Markings of the Human Body. By Louis B. Rawling, F.R.C.S. Third edition. (Lewis.) 5s. net.

It would indeed be difficult to improve on this excellent book. It is the standard work on the subject and enjoys a well-merited popularity. Seven new plates have been added to this edition, and if there is one subject in which diagrams help it is surface-marking. We heartily congratulate the publishers on the excellent production of the work.

Change of Address.

Dr. H. E. Cuff, from the North-Eastern Fever Hospital, South Tottenham, to Woodside, Bookham, Surrey.

Dr. J. H. Donnell, from Queen's Hospital, Birmingham, to 30, Sea Bank Road, Liscard, Cheshire.

Mr. L. A. Dunn, from 51, Devonshire Street, W., to 9, Park Crescent, Portland Place, W.

Dr. T. A. I. Howell, from 62, Upper Richmond Road, to Oriel Lodge, 59, Upper Richmond Road, Putney, S.W.

Dr. H. B. Kent, from Guy's Hospital to School of Tropical Medicine, Greenwich, S.E.

Dr. A. C. Nash, from Hale Road, Farnham, Surrey, to c/o Mrs. Vivien, Peachland, British Columbia.

Dr. W. H. Robinson, from the Scarborough Hospital and Dispensary to the General Infirmary, Worcester.

Dr. R. Spencer Wainewright, from 49, Wickham Road, Beckenham, Kent, to 7, Grand Avenue, Hove, Sussex.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Appointments.

Civil.

Hodgson, Stanley, M.D., B.S.Lond, M.R.C.S., L.R.C.P. Lond., has been appointed District Medical Officer to the Salford Union, and Divisional Police Surgeon to the Salford Police.

Kent, H. B., M.R.C.S., L.R.C.P. Lond., has been appointed to the West African Medical Service.

Robinson, W. H., B.A., M.B., B.C. Camb., has been appointed House Surgeon to the General Infirmary, Worcester.

Sharpe, F. A., M.B., B.S. Lond., D.P.H. Leeds, has been appointed Senior Assistant Medical Officer to the Monsall Fever Hospital, Manchester.

Military.

Lieutenant W. H. S. Burney, R.A.M.C., has been posted to Chatham for duty, and Lieutenant W. Leckie, R.A.M.C., to Shoeburyness.

X-ray Diagnosis in Dental Surgery.

DENTAL LECTURE AND DEMONSTRATION BY Dr. C. J. MORTON.

Gentlemen,—The X-rays are constantly used in the Dental Department of this hospital, and no doubt you have had frequent opportunities of seeing skiagrams of the various conditions of the jaws and teeth in which they are required to form an acurate diagnosis. The examination authorities have recently been asking questions on the methods of using the rays in dental practice, and no doubt, in the immediate future, the examiners will also expect you to interpret skiagrams, a branch of the subject which will be of much more practical use to you in your future work. Mr. Maggs has therefore asked me to give you a demonstration, and I propose, firstly, to show you the apparatus and the methods of using it, which will best be done by demonstrating the actual taking of a skiagram, and then to describe very briefly the conditions of the jaws and teeth, in which you will find that X-ray diagnosis is useful, and to show you by means of prints and skiagrams the appearances of the more common diseases.

(The normal appearances on the fluorescent screen, and the usual methods of taking skiagrams on films and plates, were then demonstrated.)

The methods are practically the same as those used in medical and surgical work. But there are certain special difficulties in dental diagnosis, and these arise from the fact that shadows of the structures of both the right and the left sides of the jaws are thrown on the fluorescent screen and appear in a skiagram. As you have seen on the screen, the picture is a very confused one. There are so many shadows of different densities overlapping and running into one another that it is difficult to distinguish between them, and it is therefore quite impossible to make a diagnosis from a screen examination in the majority of cases. The same confusion, although in a lesser degree, is shown in a skiagram if it is taken in the ordinary way, that is, straight through from side to side. The shadows of the right side are mixed up with those of the left, and it is sometimes impossible to say to which side they belong. This may happen even with erupted teeth, and the difficulty is still greater in cases where finer detail must be shown, such as the structure of tooth follicles and diseases of the teeth, bone and soft tissues. For example, a follicle may be completely obliterated by the denser shadow of a fully-formed tooth on the opposite side if the latter happens to be in a direct line with it. This may occur in an otherwise really good photograph showing, perhaps, the whole of the skull and the cervical vertebræ, and in such a case the photograph is useless as a skiagram for diagnostic purposes. By the use of a suitable tube, or, better still, by a stereoscopic view, the side that is nearest the plate can be made to stand out fairly distinctly: but these methods do not entirely get rid of the effects of the superimposed shadows. Consequently a skiagram, if it is taken in this way, does not necessarily give you the definite information that is required to make an exact diagnosis, and doubtless this is the reason why the X-rays have not been more generally used in dental practice.

I now adopt the following method, which I find disposes of this difficulty and gives all the information that it is possible to obtain and usually all that is necessary. I aim at obtaining a clear view—that is, one that is not interrupted by shadows from the opposite side—of the particular part of the jaw that requires investigation, and of that part alone. To do this the rays must be directed so that they pass first through the soft tissues, and these only on the one side, and then through the jaw on the other. The direction of the central rays of the tube is easily ascertained by making a screen examination. The patient's head is then placed into the proper position so that the rays can only pass through the part required. If, for example, the right side of the mandible is examined the head is inclined towards the right, so that the left body is tilted upwards and the rays can pass under it. For the right maxilla, the mouth is propped widely open and the head tilted in the same way until it is seen that the rays pass through the cheek between the upper and lower teeth of the opposite side. Care must be taken that the left lower teeth do not get in line with those of the right upper jaw.

In this way it is possible to obtain a clear view of any part of the upper or lower jaw, with the exception of the incisor regions. Even the condyle and coronoid process can be shown clear of the shadows of the opposite side. The tilting of the head, however, gives a somewhat oblique view of the parts. There is considerable distortion of all the surrounding structures, and the opposite side of the jaw runs upwards at an acute angle. Consequently in a skiagram taken

in this way, the result, from a photographic point of view, is not a good one, but it gives the information that is required, and so the accompanying distortion may be disregarded. I prefer to use the plate in all cases where it is possible to do so. In the incisor region a piece of ordinary photographic film wrapped in paper to protect it from the light must be used. The film is passed behind the teeth and held there by the finger, or preferably by a specially-fitted rubber mould, and the tube is placed in front of the mouth.

When making a diagnosis it is always advisable to have the patient present so that you can compare the skiagraphic with the clinical appearances. Sometimes it is of use to take a skiagram of the unaffected side also for comparison. The diagnosis should be made from the skiagraphic plate, and not from a print. The latter always loses in detail, and sometimes shows things that are not present in the original plate. This loss of detail is unfortunately very great when the skiagram is reproduced for publication, so that structures which show clearly when the plate is viewed by transmitted light are only too often unrecognisable in the picture.

The normal appearances are shown in these skiagrams, and you will see that it is easy to recognise and distinguish between enamel, dentine, dense bone, and alveoli. But the finer details can also be seen if the skiagram is taken in the way I have shown you. In these plates, for example, in the skiagram reproduced in Fig. 1, you can see clearly the structure of the tooth follicles, the periodontal sac, the little bulbous endings encircling the fangs, the dental canals, and, as in this specimen, rubber fillings in the dental canals.

I find that the rays are most frequently employed to ascertain the presence or absence of unerupted teeth and of buried fangs. For the proper regulation of the teeth it is necessary to know if the permanent teeth are present, and if they are developing properly. The relative position of the tooth follicle to the jaw and to the neighbouring teeth must be determined. In some cases the tooth will be found to be lying horizontally or inverted, or it may press on and produce absorption of adjacent fangs. Sometimes they are placed so that they cannot erupt in a useful position until a temporary or permanent tooth is extracted to allow them to do so. It is equally important to know when any of the permanent teeth are absent, as then the corresponding temporary ones must be retained as long as possible to allow the jaw to develop properly. The amount of absorption of the deciduous tooth-fangs should therefore be ascertained in these cases.

Supernumerary teeth, as a rule, do not require extraction until after they erupt. They may, however, lie in an inverted position. Occasionally it is useful to know whether any are unerupted. In the case of a boy, sent to me by Mr. David Thomson, the film shows a partially erupted supernumerary lying behind the right central incisor. This, of course, could be seen; but there is also an unerupted supernumerary lying behind the lateral incisor on the same side. Its presence was suspected, but the skiagram at once decided the matter and the proper treatment.

Retained roots are frequently the cause of serious trouble. They may lie covered by gum, and be overlooked until symptoms arise that necessitate an X-ray examination. The skiagram should show the condition as well as the position of the fang.

Acute alveolar abscess is usually easily diagnosed; but in some cases, instead of pointing in the gum, the abscess burrows, sometimes to the palate, simulating disease of the palatal bones, or to the molar region, or it may point in the cheek or under the chin. Sometimes, also, it starts from an apparently healthy tooth. In these the rays are of use in showing the teeth that require extraction.

In chronic abscess of the jaw or alveolus it is very important, from the point of view of treatment, to find out the actual condition and the cause. It may be due to retained roots, eroded fangs, impacted teeth, etc., or to caries or necrosis of the bone. An abscess cavity shows in the skiagram as a translucent area. Its walls are less dense than the surrounding bone, and present an irregular and eaten-out appearance. This skiagram (Fig. 2) shows the result of suppuration in the alveolus.

Caries and necrosis following an abscess, or due to syphilis, phosphorus, mercury, etc., can also be recognised by the irregular translucency of the affected bone. The skiagram should show whether any sequestra are present.

Impacted wisdom teeth are frequent causes of abscess, and they may also give rise to other and very serious symptoms. Severe local pain, pain referred to other parts and simulating rheumatism, enlarged lymphatic glands, paroxysmal neuralgia of the head or shoulder, obscure nerve symptoms, and even epileptic seizures have been produced by this condition. The spasm of the

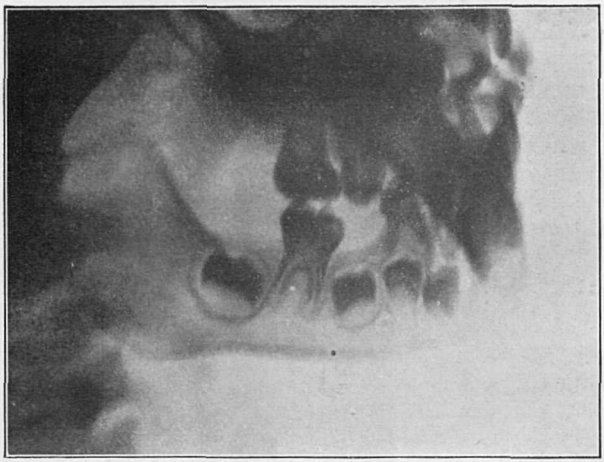


Fig. 1.

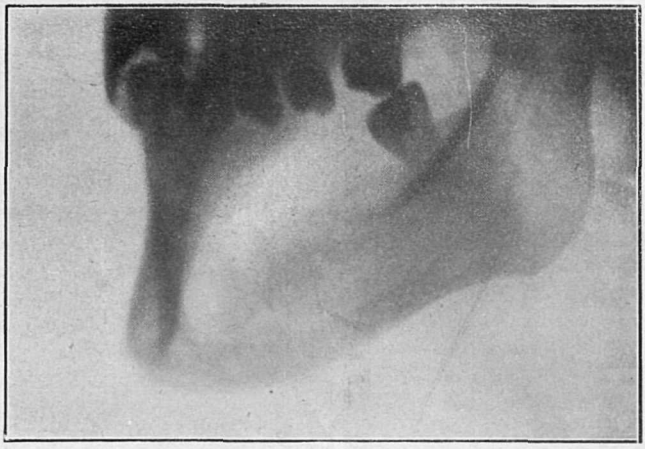


Fig. 2.

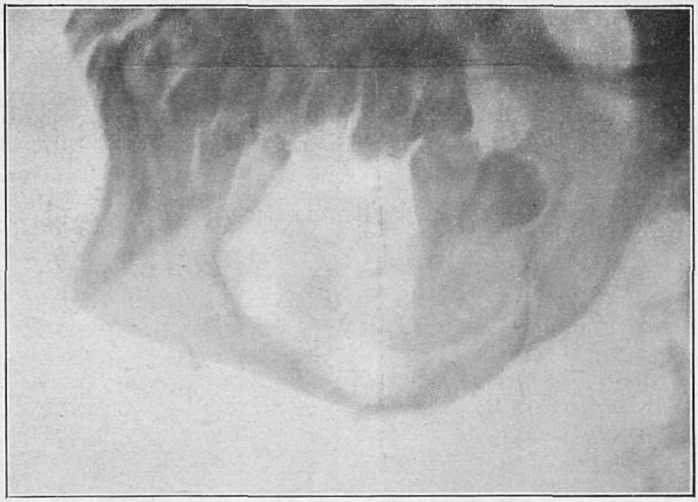


Fig. 3.

Illustrations of X-ray Diagnosis in

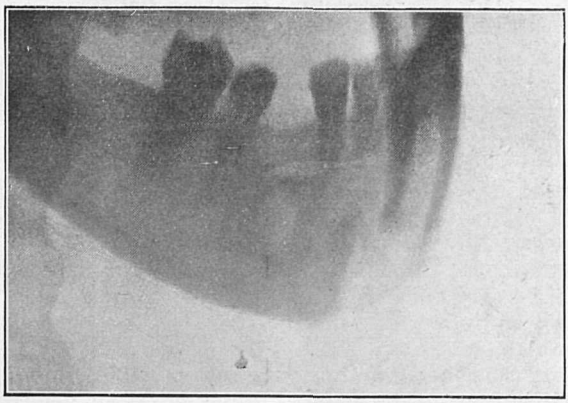


Fig. 4.

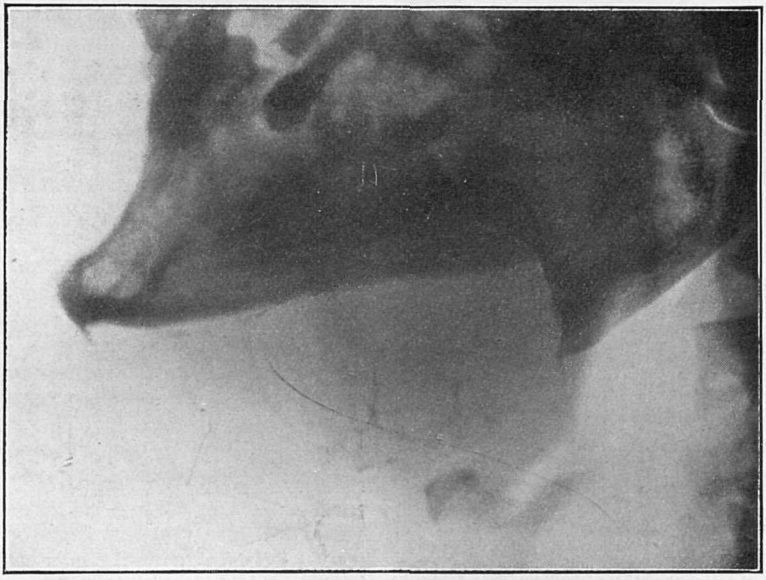


Fig. 5.

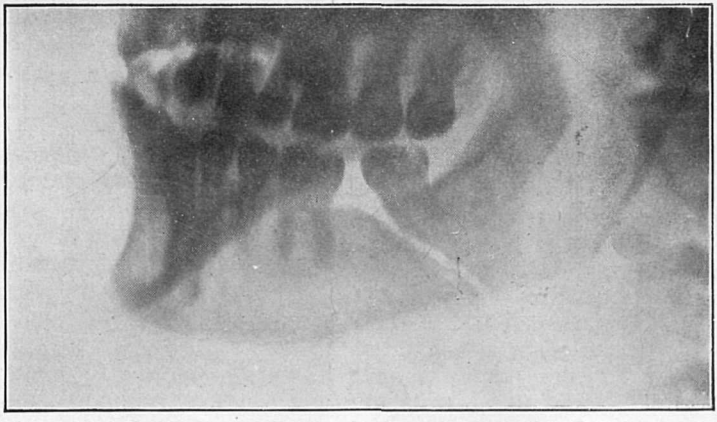


Fig. 6.

masseter muscle which usually accompanies it makes an examination by the ordinary methods difficult or impossible, but the rays at once clear up the nature of the case. Impaction rarely occurs in the maxilla. When it does happen there, it may be accompanied by plastic exudation and involvement of the portio dura. As a rule it is the lower wisdom that becomes wedged in between the neighbouring tooth and the ascending ramus. It may press on and cause absorption of the roots of the second molar, and this is frequently followed by abscess formation. It may be directed obliquely backwards and outwards, or it may lie horizontally, sometimes with its crown embedded in the ascending ramus. This skiagram (Fig. 3) shows the latter condition associated with an endothelioma of the left body of the mandible.

As a rule the symptoms appear in young adults, but the age of the patient is not always a reliable guide. In this case, sent to me by Mr. W. F. Mellersh, the third molar is seen lying horizontally. The patient was a lady over fifty years of age, and the symptoms had only recently developed.

The chief points to be noted are whether the tooth is impacted or diseased, or causing absorption or abscess of the second molar, and whether it can erupt in a useful position. On these depend the proper line of treatment, namely, the extraction of the second or third molar, or of both.

Cysts are recognised as more or less rounded translucent areas with uniformly regular and smooth walls. The slowly-growing cyst gradually hardens and condenses the surrounding bone, so that in the skiagram the translucent area is seen to be enclosed by a thin layer of opaque bone.

Dental cysts occurring at the roots of fully-developed and erupted teeth, odontoid cysts due to distension with fluid of the tooth follicle, and cysts following abscess or forming round a diseased root, can all be recognised and distinguished from other diseased conditions by their characteristic appearance. In this specimen (Fig. 4) a cyst is shown surrounding a small piece of bicuspid root.

Odontomes, such as the fibrous and calcareous varieties, show irregular thickenings of the follicle with obliteration of the follicular sac.

The nature and extent of the various tumours, simple and malignant, that affect the jaws can usually be determined. This skiagram (Fig. 5) of a case of recurrent epithelial odontoid shows distinctly the extent of the tumour, the expansion and rarification of the bone, and the minute bony trabeculæ scattered about in its substance. The tumour shown in this specimen (Fig. 3) was found, on microscopic examination, to be an endothelioma.

Disease of the antrum is usually recognised by the symptoms or by transillumination. But the X-rays will also show tumours or fluid in the antrum, and sometimes they give information of the cause of the trouble that cannot be obtained by other methods. Foreign bodies, such as drainage tubes or roots of teeth that have slipped back into it, are easily seen. The fangs of molar, bicuspid, or canine teeth may project into it and become eroded. Fillings of these roots have been known to pass through the ends and cause irritation. Of the other rarer conditions, exostoses of the fangs is one that may give rise to severe and obscure symptoms. They may cause pressure troubles of adjacent teeth, and these may easily be mistaken for the offending one. They are frequently multiple, and all the diseased teeth must be discovered and extracted to effect a cure. Absorption of the fangs of permanent teeth sometimes occurs, and it is as well, in these cases, to discover, and to warn your patient, which teeth he will lose. Occasionally, also, you may require the aid of the rays to diagnose enamel nodules between the fangs, dentine nodules in the pulp cavity, warty teeth, polypus of the pulp, and salivary calculi.

Fracture of the jaw is the only other subject to which I need refer. In the mandible, if the fracture occurs in the usual position about the canine tooth, it is, as a rule, easily detected, but even here it is sometimes overlooked. Fractures about the angle, coronoid process, and condyloid neck are often very difficult to detect, and even after the position of the fracture is shown by a skiagram it may be impossible to feel any irregularity or to obtain crepitus. Frequently they are multiple, a fracture of one body being accompanied by another on the same or on the opposite side. In this case both condyloid necks are fractured. The line of the fracture should be noted, whether, for example, it runs into an unerupted follicle, or into a tooth fang (Fig. 6), and may thus give rise to after-trouble. Sometimes a V-shaped portion of the alveolus becomes separated and is likely to slough. The stereoscopic method is often of use to show the amount of displacement and the relationship of the line of the fracture to the teeth. In the upper jaw the signs are usually sufficiently evident. To detect obscure cases by the rays the skiagram must be very carefully examined,

and the appearances compared with the normal shadows. In this way it will be possible to detect slight irregularities in the outlines, or sharp spicules of bone indicating a fracture of the body, or one about the zygoma or malar bone.

The importance of a negative X-ray diagnosis in these as in all other cases of dental disease should not be overlooked. You have seen the conditions that can be shown by the rays, and will be able to judge from the appearance of a skiagram whether it is a satisfactory one from which you can make a diagnosis. If it is satisfactory, you know that it gives a true picture of the part, that it omits nothing that is of importance, and that it shows clearly all that is present.

Dental Notes.

It is hoped that new men will take the first opportunity of putting their names on the lists in the smoke room for the freshers' matches. In the past we have always been well represented in this respect—Pritchard in the Rugger XV., King, Robertson, Whiteley, Glover, and Humm in the Soccer team, not to mention Hunt at Gymnastics, and Barnett and Kemp in the Boxing section. We trust that you freshmen will follow up these achievements.

In the Dental Buildings drastic changes are seen. The Conservation room, clothed in a new coating of white paint, and adorned by Sister with a tasteful display of ferns, is indeed "a thing of beauty and a joy for ever."

The pupils are now housed in the large laboratory upstairs, and the senior men work on the ground floor. These laboratories have been cleaned, painted and overhauled, and the ventilation of the ground laboratory, which last term left something to be desired, has been greatly improved.

In Out-patients we share the fine new buildings fronting the road by the medical buildings; these are light, airy, and give plenty of room to work in.

A rather serious disadvantage is the nearness of the gas room to the ordinary extraction room, resulting in sounds from one room being heard in another.

All freshmen should make a special point of attending the first meeting of the Dental Society, which is to be held in the Physics Theatre on Friday next, October 9th, at 4.30 p.m. The meeting is preceded by tea, free to members, at 4 p.m. Mr. Spiller, the President, will preside, and deliver an inaugural address.

The meetings are held monthly; at each a paper is read, followed by a discussion, in which all present are requested to join. Members are invited to present, as casual communications, models and specimens of interest.

A prize of £1 is offered for the best series of casual communications shown during the year. For the best paper read before the Society during the year a prize of £5 is offered.

From the Gazette's Special Pathologist.

V. H. H., Westcliff-on-Sea.—*Reaction* strongly alkaline. *Sp. gr.*, 1021. *Albumen*, a trace, partly nucleo-proteid. *Blood*, vide infra. *Sugar*, absent. *Microscopical examination of the centrifugalised deposit*: The deposit is considerable in amount, and is of a peculiar purple colour. It consists of triple and amorphous phosphates, ammonium urate spherules, minute traces of blood, and abundance of bacteria. Its peculiar colour is due to the presence of indigo, most of which is contained in the urates, but part of which occurs as free crystals. It has been extracted with liquid carbolic acid, and its characters confirmed by re-crystallisation. The red colour of the urine is due to the presence of indigo red, the minute traces of blood being insufficient to contribute to this colouration. No tube casts, traces of pus, or further abnormalities are found.

The condition appears to be bacteriuria with alkaline decomposition of the urine leading to the separation of crystals.

The irritant effects of the crystals would explain the trace of blood, but the possibility of calculus should be taken into account. PATHOLOGIST.

Births.

CURRIE.—On August 23rd, at Manor House, Rosebank, Cape Town, to Dr. and Mrs. O. J. Currie, a son.

SPRIGGS.—On September 16th, at Bryanston Street, Portman Square, W., the wife of Edmund Ivens Spriggs, M.D., F.R.C.P., of a daughter.

Marriages.

BRAILEY—CRIMP.—On September 12th, at St. Mary Abbot's, Kensington, William Herbert Brailey, 21, Lansdowne Place, Hove, elder son of W. A. Brailey, 11, Old Burlington Street, W., to Gertrude Agnes, only daughter of the late Santo Crimp and Mrs. Santo Crimp, 18, Matheson Road, Kensington.

WATNEY—CROSSLEY.—On September 16th, at St. Thomas's Church, Belfast, Herbert Andrew Watney, M.B., B.S., son of the late Rev. James Watney, of Canwick, Lincoln, to Olive Emily, second daughter of the late Arthur C. Crossley, of Belfast.

Death.

COLE.—On 23rd September, at sea, near Singapore, W. Henchman Cole, M.R.C.S., L.R.C.P., Surgeon, P. and O. s.s. Malta, eldest son of W. Hammond Cole, late of Survey of India, of the Dene, East Grinstead, aged 30.

Notes of a Roving Guy's Man.*

VIII.

Like Göttingen, Prague is a town that has figured largely in the history of surgery. Here the first complete extirpation of the bladder was done more than fifteen years ago; here gastrojejunostomy was perfected, tracheoplasty was first tried, and one of the first total extirpations of the larynx was done here. It is one of the finest and most picturesque of cities, this, and I know of few more impressive sights than that which one sees on a summer afternoon from the heights behind the new railway station. The city lies below in a blue-grey haze, through which shines the sheet of the Moldau like molten silver, and above which gleam the spires of the Hhradschin. Colour upon colour and shade upon shade flit round the houses and linger round the old gables and the red tiles of the newer houses. It is a picture worthy of a Turner's painting, and there are parts of it which for delicacy and beauty rival the best that one can see at Lake Garda or in the lagoons of Murano. The town itself is full of interest, and the medical student will probably spend a few days in thorough enjoyment before he makes steps for the old clinics.

My first visit was to the gynæcological wards to see Professor Kleinhaus. The gynæcological and obstetrical wards are in the same building, an old structure some distance away from the general hospital. The wards are large, but old, the ventilation is very bad, and many of the arrangements are primitive in the extreme so far as nursing conveniences, lavatory arrangements, and so forth, are concerned. Nevertheless, much good work is being done here under conditions which can scarcely be called excellent or satisfactory. Prague possesses two universities—the German and the Bohemian. The two groups of students are more or less at daggers drawn, though in the gynæcological building they have to live together to some extent. This is not, however, a real union, for the Bohemian block is quite distinct from the German block and has its special staff. The Prague student does no externing, for there is no "district." All the patients come to the clinic and are delivered there, and some forty to fifty students dig in the building, lodging on the ground floor, where they have a large common room, and are separated by a huge quadrangle from the Bohemians. The patients speak only Bohemian, and the Germans, with all their alleged contempt for the language, have to speak it as well. The relations between the two parties are, to a stranger at least, hugely amusing. A haughty stare is exchanged when the two students meet on the street, and one is told, "Oh, that's So-and-So. He is assistant to So-and-So at the Bohemian clinic, and doesn't know a thing!" At the general hospital, an equally old and bad structure, things are really very interesting. The professors and assistants are all very courteous; they give up much of their time to the stranger, and are keen to show him round. And there is really much to see, and as lectures begin very early in the morning and run consecutively, one can do a great deal in one day. I went to hear Ritter von Wartenhorst, the head of the medical clinic, who is better known to English readers as Professor von Jaksch. His lectures are delivered in an interesting way, but can certainly not compare with those of Professor Kraus. Then I went over to the surgical clinics, there being nothing specially interesting at the orthopædic department, to see Professor Wolfler operate. The German surgical clinic is, like the medical and gynæcological, housed in an old building, a part of the general hospital, which is thoroughly unsuitable for a hospital. The wards are cramped and close, both lighting and ventilation being quite inadequate. The operation theatre is of medium size and very finely lit by skylights. When I expressed my admiration, I was told, "It's by no means so fine as you think. At midday it's a little hell, and the only person that's really comfortable is the patient when he's anæsthetised." The great heat and the comparatively low roof are responsible for this, and, as a matter of fact, most of the operations are done in the small theatre, which is not so well lighted, but much cooler.

The work at the clinic is very interesting, and the assistants have a much better time of it, so far as operative work is concerned, than in Germany. Nevertheless, they grumble. When operations were over, I was taken to the common room where the assistant on day-duty lives, and all the grievances were related. Lunch came in—excellent soup, an excellent stew and vegetables, compot and pudding, with the usual beer, far better fare than is ever put on the Residents' table, and a growl went up, "Again this cursed stew; one gets nothing but goulash in this menagerie!"—from which it may be seen that the food grievance is not limited to the College. The assistants live out, coming to the clinic at half-past eight in the morning, returning for lunch at two, and coming back for afternoon duty at four. At eight they leave, and are free the rest of the evening, except the man who has to take night-duty. The man on day-duty remains at the clinic all day and gets his board there. Compared with a German clinic, the life is by no means hard, and the opportunities are to be envied. Each man does not only minor operations, but what may rightly be considered very major ones—extirpation of goitres, amputation of breasts, appendices, herniæ, and so on. In the common room the men are convivial and hospitable, and one realises for the first time the vast difference between the German and the Austrian clinic from a social point of view. This difference is equally striking at operations. The professor, or chief assistant, is not the formal, black japanned little god that he is in Germany. He is a chief to be respected and loved, who treats his staff as if they were real colleagues. It is unheard of for the German chief assistant even to suggest a step during an operation which the professor does; the Austrian man accepts

*Series I., II., III., IV., V., VI. and VII. of Notes appeared in Gazette of April 4th, May 2nd, May 16th, June 13th, August 8th, August 22nd and September 5th.

suggestions freely, thanks his assistant with a nod or a cheery "You're getting on," which is worth more than a heap of pattings on the back after the operation is finished. For the graduate who wishes to do operative surgery I cannot give better advice than that he should try and obtain an assistantship at an Austrian hospital. Such assistantships are much easier to obtain here than in Germany (where, indeed, it is now, after May, impossible for a foreign graduate to become an assistant), and one can stay as long as one likes—a month or a couple of years. The opportunities for practical work are greater than in Germany, and the work is therefore more interesting.

The newest novelty here was of course Professor Liebling's "Galalith" button for intestinal work. The button, which is in all respects similar to the Murphy, is made out of casein hardened in formalin. It can be sterilized by boiling (after which it has to be placed for a few minutes in a solution of carbolic acid) and is absorbable, the small metal flange, which protects the spiral, being too small and weak to give rise to any inconveniences. The button has been used several times with great success, and the only thing against it is that it is expensive. For gastro-enterostomy purposes it is eminently suitable, if one wants to use a button in that operation. One of the original buttons and one of the new models were presented to me to experiment with, and I hope to try them both some day. A large amount of intestinal work is done at the clinic, and Professor Liebling is specially keen on livers, having done quite a number of Talmas lately. The curious thing about the Talma is that its results can never be foretold. In some cases it acts marvellously; all the ascites disappears, the liver diminishes in size, and the patient is to all intents and purposes cured, and this cure is permanent. In others the operation is without the slightest effect. The ascites remains or increases, the liver enlarges steadily, and the patient is no better than before the operation. And yet there is apparently no difference between these cases clinically. These results of Talma's operation call attention to the need of reinvestigating cases of cirrhosis. It is inconceivable that the case which benefits is clinically the same as that in which the operation is a total failure; something with which we are as yet unacquainted must be the underlying cause of the failure. One naturally thinks of meningocele operations in which, in the majority of cases, the operation is entirely a success, while in a few others the patient rapidly develops a hydrocephalus. On what do these results depend? So far as I know, no explanation has been given of this sudden development of hydrocephalus after meningocele operations, and yet it does occur. The question appears to hinge upon the differentiation of exudates from transudates, and it may be that all these lesions in which the Talma operation has really been successful are to be classed as exudates, depending on some purely local chronic inflammatory condition. The subject is a very interesting one, and one can only throw out the suggestion that some enthusiastic person should systematically examine every specimen of ascitic fluid he can obtain, cytologically and cryoscopically, chemically and physically. Only by means of a series of such observations can one hope to settle the question, and at present the indications for the performance of a Talma can hardly be said definitely to exist, as in no case can the operator foretell what will be the final result. All that he can say is that 50 per cent. are cures, and 50 per cent. total hopeless failures.

At all the Austrian hospitals a large number of goitres are admitted, and the operators are therefore experts in goitre extirpations. The operation is always done under local anæsthesia; the patient hardly feels anything, and is able to speak and assist. That this conscious condition is a real help to the operator I was shown on more than one occasion. In all goitre operations, especially in the bloody "wedge excisions" of Mikulicz, the great danger lies in the operator damaging the recurrent laryngeal. When this is done in an unconscious patient, the operator only finds out his mistake when it is too late to remedy it. When the patient is conscious, however, traction on the nerve is at once made evident by a characteristic alteration in the voice. It is, therefore, really a help, when working loose the lateral portion, and especially at the critical point, when the inferior thyroid artery is being tied, to hear the patient talk or say "Ah!" The demonstration of this fact is very easy. One has only to pick up the nerve as it lies exposed after the lateral lobe has been removed, deep down where the thyroidea inferior runs, and to pull slightly at it. While this is done the patient cannot say "Ah!"—the sound is a mere breath sound, or E—e. Another thing is, that this constant talking slightly distracts the patient's attention from the operation itself. The extirpations of goitres are, in fact, quite jovial operations. All patients feel pain when the arteries are tied, and the nervous ones groan a good deal. In such cases a sponge with cognac is given them to suck, and the operator soothes them as he goes along. "Now then, Miss, say 'Ah!'—that's right; you needn't go on with it," or "Isn't it childish 'playing locomotive' like that, Miss? You'll never have a soprano voice if you go on groaning." After the operation the patient is allowed to have something to eat, though swallowing is usually painful at first. A small glass drain is invariably put in, which is removed after twenty-four hours. In exophthalmic cases two drains are left in, one of which is removed before the other. All the operating tables have a special head-rest for such goitre cases, and in every case early operation is advised, it being pointed out that sudden death is one of the dangers to which the goitre patient is specially liable. In cases of malignant disease, carcinoma and sarcoma chiefly (endothelioma occurs, but is very rare), the whole gland is extirpated, and a piece of thyroid is grafted submuscularly in the axilla or chest wall. One interesting case was a large ulcerating goitre in an emaciated old woman. This was rightly diagnosed as malignant, but at the operation a section showed that no carcinomatous tissue was present. All the operations here were very deftly and neatly done, and I was particularly struck with the able handling of an exceedingly difficult case—a

recurrent carcinoma of the tongue with glands adherent to the large vessels.

Prague will possess a very fine hospital in a few years time, the new buildings, which are really excellent, being nearly completed. The new chemical and anatomical buildings, opposite the general hospital, are also very fine. Nor should the medical student neglect to visit the fine hospital of the Barmherzige Brüder, or Brothers of Charity. I had met the late Prior, the Reverend Dr. Hek, in Berlin, and heard from him about the institution, so made a point of seeking the Heilige Geist Gasse, and visiting it. It is a large and very old building, connected with the monastery and Church of the Order. The medical staff are laymen, but all the nursing is done by the brothers, who also manage the fine dispensary—one of the best hospital dispensaries I have yet seen. Only male patients are admitted, and the wards are much finer, and in every respect better, than those of the general hospital. The Order is a rich one, and has hospitals and asylums in practically every Austrian town.

After Berlin and Prague, Vienna came as a huge disappointment. For a general description of the old hospital and its medical aspects, I cannot do better than refer to the excellent article which appeared in the Gazette, some years ago, from the pen of Dr. Brailey. Vienna is a "Grosstadt," with more than two million inhabitants, but it does not impress the visitor at first. After a few days one learns to admire the really beautiful streets, the fine "Rings," and the magnificent buildings. As a city it is interesting enough, and I found I had plenty to do. I had to deliver some introductions, one of which carried me to the Houses of Parliament, where I attended one of the most amusing and remarkable debates I have yet listened to in a house of representatives. Whenever a member got up to address the house, the opposite party (I believe there are no less than ten different parties represented) commenced to talk and shout at the top of their voices, so that it was virtually impossible to hear what was being said. In the midst of all this din comes the vigorous ringing of the chairman's bell. The most interesting part of Vienna is, however, the splendid Prater, with its swarm of people in the afternoon—a perpetual Earl's Court on a vast scale, and as interesting as the Moscow street. The Danube, on the contrary, hardly came up to expectations. It is outside the city proper, and in summer is scarcely as wide as the Thames at Windsor. At the time of my visit all the city was off its head on account of the Jubilee festivities. The Rings were disgraced with rows upon rows of tribunes, and the walls were plastered with the most hideous "artistic posters" one could imagine. The only redeeming feature was that one was able to see all sorts and conditions of people in all varieties of costume, these being members of the different nationalities who had come to the city to take part in the *Fest-zug*.

From the student's point of view, Vienna is terribly disappointing. To begin with, living is comparatively expensive, and the tipping system is outrageously developed. One has to tip everyone, from the tramway conductor to the waiter who brings you the paper. There is first the waiter who brings the wine, then the piccolo who lays the table, then the man who brings the food, and finally the head waiter who makes out the bill. The pay waiter exacts ten per cent. of your total account as tip, the beer waiter two per cent., and the rest a fraction; and all this no matter whether you merely take an ice or whether you have a six-course dinner. Then when you come home after ten o'clock at night (and who dreams of going to bed in Vienna before that hour?), your door porter—there are no latch-keys—exacts twopence fine, and this is repeated every time you come in. The Viennese are extraordinarily vain of their city: in their eyes it is the pivot of the universe, and there is nothing like it. The Vienna hospitals are really by no means excellent—the new gynæcological clinics, not yet occupied, of which I had heard so much, proved, on close inspection, to be open to grave criticism on several points. They are supposed to represent the acme of modern hospital construction. Yet I found a ward with eight windows, normally equal to accommodating at the most eighteen patients, was destined to receive twenty-four—the lavatory accommodation totally insufficient, the flushing being also inadequate, and many other minor faults here and there. Yet you must on no account criticise these things. You are met with the statement that Professor Osler has declared Viennese hospitals are the best. I doubt very much if Professor Osler said any such thing; if he did, one can only wonder what his ideal of a hospital is like.

It seems unfair to criticise too severely, and yet it appears necessary. Vienna enjoys a reputation which is rivalled by no other European university centre, and it certainly does not deserve it. This reputation is largely due to the patronage of English and American students. The courses are cheap, but very elementary, and such a course as one can obtain in Berlin, for instance, is not to be found here. Dr. Brailey's remarks about the American Medical Association I found were fully borne out by facts. There is no greater contrast imaginable than that between the excellent American Medical Association of Berlin and the corresponding Vienna Society. The latter has its headquarters at the Café Klinik—a thoroughly bad plan, which is not to be compared with that followed by the Berlin Association, whose headquarters are in a fine reading-room, where one can work in peace and quiet, and be under no obligation to anybody. The meetings, which are stiff and uninteresting, entirely lacking the conviviality of the meetings at the Heidelberger, are held in the lecture room of the Psychiatrical Clinic. Vienna swarms with American graduates, but one finds few Germans or Russians there. A great many of the courses are given in English, and no doubt, for the student who knows no German, a course at Vienna may be very useful. For one who knows the language and really wishes to work, it is not to be recommended, and Berlin, Leipsig, or even Munich, must be regarded as far superior. Clinically, of course, there is a vast amount of material;

there are good men, and the fees are very low. There are many hospitals; chief, though by no means best, of which is the General—a large, rambling, badly-built, ventilated and lit place. The lectures are, like the courses, very elementary. I went to hear Professor van Noorden, but found it very tedious, and came away early, while a look in at the surgical clinics of von Eiselsberg, Hocheneff, and Frank, proved almost as uninteresting. The chiefs rarely operate; most of the work is done by the assistants. At the Billroth Hospital one can see the veteran Gersuny, who is well worth watching, especially when he does plastic work. But on the whole the surgical side is disappointing, though to one whose first experience of Continental surgery is gained at Vienna, it will, no doubt, be interesting enough. One misses the thoroughness and catholicity of the Berlin men, just as in the lectures one misses the cosmopolitan audience. In Austria itself Vienna is not regarded so high as a school of medicine—the best men, after all, came from Graz and Prague, although it is true that Vienna produced the brilliant group of surgeons known as the Billroth School, and Viennese clinics are below those of other great cities in point of general interest.

To this I make one exception—Lorenz's Clinic. There is nothing like it anywhere else, just as there is no one like Lorenz himself. You come in the morning, crossing the two courtyards of the General to gain the miserable little out-patient department where the best-known orthopædist of the day does his work, "They are only waiting to walk over my body," Lorenz said pathetically, "to abolish the chair of orthopædics," and they treat it scurvily enough. There is one small waiting-room, much too small for the crowd of patients, a medium-sized workroom, and a tiny little operating-room, where the drains smell so that they have to be corked-up, and where the light is of the poorest. But what an interesting place it is! The three assistants, as courteous and as kindly fellows as you can meet anywhere (each seems to have stolen a bit of good nature from the chief himself, without damaging the large stock he possesses), are eagerly discussing a case of yesterday. You introduce yourself, and are made heartily welcome, particulars of the case are retold for your benefit, and the argument—whether recovery from a case of embolism with grave cerebral symptoms is possible—is vivaciously continued. Outside, in the waiting-room, the din of the in-crowding patients is each moment getting louder. One of the assistants gets up, opens the door and calls out in the delightful dialect, *Bi' sh'n, á bissl' ru-á.* Then, half an hour later, the cases are examined, and while you are interesting yourself in a couple of cases of coxa vara, a cheery voice comes floating round the corner, and a moment later the chief enters. Everyone knows Lorenz, tall, patriarchal bearded, frank-eyed, brimful of good nature and courtesy. You present your card, and ask if you may be allowed to attend his clinics, and in a moment you are made to feel that you are not an intruder, but that you are really welcome. Like Kraus, Lorenz is a man one can be pardoned for "enthusing about." He is the incarnated "*Liebenswürdigkeit*," a chief under whom it must be a pleasure to serve, a lecturer whom it is a delight to listen to. Soon the little operating-room is crowded, and the cases he is going to demonstrate come in. He begins to talk about the natural position of the femur, addressing each of his hearers in turn, until he notices a puzzled look on a man's face. "Ah, you do not follow? Very well, I will try to explain in English, although you must forgive my mistakes." The apology is unnecessary; he talks English easily and fluently, and for an hour you listen to a series of interesting demonstrations. Like all great men he is enthusiastic, and has his fads. Just hear him on cuneiform osteotomy. I had been seeing quite a lot of coxa vara cases, and this one, a boy with the adolescent form, interested me vastly. It seemed an ideal case for doing a Whitman. How was he going to treat it? Bloodless, of course. He proposed to fracture the neck under an anæsthetic, and put it up in plaster. If that failed, then do a linear osteotomy. Why not a Whitman? In a moment my arm is grasped, and I am led to the blackboard, where a vivid drawing of a linear osteotomy is rapidly sketched. "It does everything one wants; cuneiform osteotomy is laughable—simply ridiculous. Whatever's the use of doing a complicated operation when one equally simple suffices?" A case of tubercular hip; he measures the shortening in a moment. "I am an orthopædist, gentlemen," he remarks, "but as you see I don't carry a centimetre measure. One learns to judge by experience how much shortening there is." One of those present suggests that the case may be an old fracture—an absurd suggestion, but he goes patiently into the matter, and puts the case clearly. A woman comes in; he is enthusiastic in a moment, for this is a patient who, when a child, was treated for wry-neck with the open operation, relapsed, and was cured by subcutaneous myotomy. There is almost no sign of his operation; the old scar is still very evident. He is justifiably proud, and claims that this case is a proof of his theory that caput obstipum is a primary congenital cervical scoliosis, to be cured only by correcting the scoliosis. The open operation is unjustifiable, because unnecessary; treat the scoliosis after dividing the muscle. Then, when the demonstrations are over, he goes round, shakes hands individually, and invites everyone to "come whenever you like; I am always pleased to see you." No wonder Lorenz is one of the most popular men in Vienna. And yet you come away from his clinic only half satisfied, and with your mind full of doubts as to the correctness of his methods. Is it only necessary to do a subcutaneous myotomy for wry-neck? Are "bloodless" refractures of femoral necks justifiable? Are forcible corrections without danger? You recall to mind that a bloodless correction of a wry-neck has caused death by twisting of the vertebral artery, and you wonder how it is that at Lorenz's clinic they have an experience of fat embolism of which you have only read. Bloodless methods are excellent, but it is just possible the Master's enthusiasm may carry one too far, and what is safe in practised hands like Lorenz's, may be very dangerous in those of the beginner. There is, of course, much that is really very good. One of the

best things one sees here is the linear osteotomy of the lower end of the femur. The cortex of the shaft, just above the condyles, is chiselled through, the chisel being very sharp, and driven in without using the scalpel from the outside, and then the inside part is fractured by forcible bending. This seems a simple and convenient method, and appears to give excellent results. Equally good are his repositions of congenital hip luxations, and his forcible redressement of club feet. At this clinic one sees the most exaggerated and apparently hopeless forms of the latter deformity. He has learnt to recognise these cases at a glance, and remarks, with a smile, "Ah, there's another Galician!" for the majority of these neglected cases come from the Polish districts. With infinite care and manipulation these feet are corrected and put up in plaster, the results being, in many cases, striking. We, with our frequent and often unnecessary tenotomies, might take a leaf out his book, and learn a wrinkle or two from his methods. They show, at least, what patient, persevering correction can achieve.

One sees a large variety of orthopædic cases at this clinic, rivalled only, perhaps, by those that are to be met with at Berlin. Coxa vara and valga, spastic deformities, congenital hips, tubercular joints, wry-necks, all sorts of feet, from the ordinary flat to the interesting pes calcaneus sensu strictiori of Nicoladoni, fractures, and old deformities the results of fractures, scoliosis, and all varieties of spondylitis. Constant attendance here must make a man fully proficient in diagnosing the whole gamut of things orthopædic, and certainly the clinic is one of the most interesting in Vienna. Yet it is not catholic, in so far that open methods are not given a fair chance, and surgery, as a legitimate aid to manipulative treatment, is put in the background. One recognises at the beginning that the orthopædist should resort to the knife as rarely as possible, just as rarely, in fact, as he should resort to apparatus; but, at the same time, one realises that in many cases a judicious use of the scalpel is a very necessary and an entirely legitimate help.

Apart from the Lorenz's clinic, there are other places of clinical interest in Vienna which are well worth a visit. One of these is Professor Silbermarck's clinic, where one can see a good deal of excellent bone work. Here a feature is the bone fillings with iodoform wax, the so-called Mosetig method. Usually such fillings are unsatisfactory, as they work loose and lie like an artificial sequestrum in the large cavity which they are supposed to fill. This, it is said, is due to the fact that they have been carelessly inserted. Silbermarck dries out the cavity completely with a special blast of hot dry air, after chiselling away all diseased bone, and thus getting a healthy locula. He insists upon the importance of this step, and his results are excellent. The skiagraphs show that the cavities are being gradually filled up by supporting tissue, whether true bone or not it is somewhat difficult to say. The objection to this method, of course, is that it entails the use of special and somewhat cumbrous, not to mention expensive, apparatus, while other workers have claimed equally good results after using less complicated methods.

A few notes about German and Austrian student life may not be uninteresting to Gazette readers. The average foreigner comes to the Continent, and hardly enters into student life proper, with the result that he takes away the most ridiculous impressions. The great point in which the German (and, to all intents and purposes, the Austrian as well) student differs from the English is that he is really a power, and recognised as such. There is a union between all the Universities, an interchange of professors and students which, under present conditions, is quite impossible in England. The German student, therefore, is much less narrow in his prejudices and views than the English University man; he recognises that there are other rivers besides Abana and Pharpar. What is more, the extensive development of student institutions promotes the solidarity of University men. A matriculate of Berlin is able to work at any German or Austrian University he chooses, and then to come and take his final at his real Alma Mater; but wherever he goes he finds colleagues, club mates who make him heartily welcome. These student clubs are officially recognised by the University authorities, and lists of them are included in every calendar, while their notice boards hang alongside the official baize boards in the halls of the University. If anyone wishes a proof of their solidarity, the present Austrian student's strike, in which the pupils took up the cudgels for the professors, and successfully maintained the rights of the lecturers, may be referred to. Such institutions fall into two great groups, the *Corps* and the *Burschenschaften*. The former are much older, some of them dating back to the fifteenth century. They are essentially social clubs, frankly convivial, and their great principle is *Ergo bibamus*. Most of them are expensive institutions, and membership of some of the crack corps entails a heavy annual outlay, so that their membership is necessarily limited. The stranger can identify a Corps man by his cap, which is somewhat like a lancer's, and not like that of the member of a Burschenschaft, who wears a flat peaked military cap. As there are a great many different corps it is very difficult for a stranger, however, to distinguish each variety by its special colour. The constitution and rules of the majority of corps are very similar to those of the Burschenschaften, and one account will suffice for both.

The Burschenschaften, on the other hand, are associations formed with some definite object—usually political or semi-political. They arose out of the volunteer movement at Jena during the Napoleonic wars, when German studentdom covered itself with gore and glory on behalf of the Fatherland, and they must be reckoned as the most powerful and numerically the strongest of student combinations on the Continent. Their members are divided into three classes—*Fuchsen*, *Burschen* and *Alte Herren*, and their administration is vested in an annually elected committee, consisting of a president, two vice-presidents, secretary, treasurer, and four or more active m embe representing the two last classes. When a student

wishes to join a corps or Burschenschaft he applies to one of his friends who is a member, and is duly proposed. Then he is "observed" for a month, and if this period of probation is successfully passed, he becomes a *Fuchs* (Fox). The Fox has no privileges, but he has certain obligations which must be scrupulously observed. He wears a smaller and less vivid band than the member, to whom he stands much in the same relation as a fag to his fag master. He has to attend the weekly meetings of the association regularly (at least three times a month), and has to remain till the official part of the proceedings terminates. He has to fight at least once, and has to guard the honour of his corps zealously, to attend fencing lessons, and to interest himself actively in the objects of his association. With the duelling question I shall deal later, and here it need only be said that the Fox can demand to fight with a full member if he is "insulted." At the end of his first year he has to pass an examination, but before that time he is solemnly baptised and receives his "Kneipe" name (lit. saloon name). The baptismal ceremony is great fun. The Foxes stand in a row, and each receives an appropriate name. Thus a lanky Fox may be christened "Spider"; a stout one, "Plumpy"; a clumsy one, "Briareus," and so on, and the name sticks to him for his life, so far as the association is concerned. Then a jug of beer is solemnly broken across each one's head, and the ceremony is over. The examination falls into three parts, and is purely *viva voce*. The Fox is examined on history—the history of German universities generally and the Jena movement, and the history of his own corps; on the objects of his association, its political purpose, &c., and finally on the "code of honour," on his proficiency in fencing, and on "the drink code." The examination over, he becomes a *Bursch*, or full member, with all the privileges of membership, and is eligible for president or committee man. He has to fight four times, and then becomes "inactive." Finally, when he becomes qualified, he is made Alte Herr, or old gentleman, which is equivalent to consulting member. Nearly every professional man is an "old gentleman" of some corps or other, and still, on occasions, attends the meetings and emulates the younger members. These meetings themselves are always interesting. Having many times enjoyed the hospitality of these corps, both in Germany and Austria, and both as guest of the members and of the old gentlemen, I can testify to their interest. The meeting starts at about half-past eight at the regular meeting room, usually in some well-known beer-house. You enter with your host and are introduced to the president and vice-presidents, all garbed in swagger uniforms—white breeches, high, black-polished riding boots, black or green velvet coat, large black hat with pendant ostrich feather, white leather gauntlets and belt, formidable sword, and flowing scarf of the colours of the corps—and take your place at the top table. The waiter comes round with a basket of paper slips, each of which is a beer ticket. Your host grabs a handful of these for you and another for himself, and introduces you to your neighbours. By and by others come up from the side tables, and soon you begin to feel quite at home. There is a din of conversation, for everyone is volubly talking. At the bottom table sit the two vice-presidents, each with his sword before him, and attended, like the president, by a uniformed Fox, who acts as aide. The meeting is formally opened by the president who strikes his sword thrice on the table and calls out, "Ad loca—silentium," the contrarii, or vice-presidents, repeating the order in stentorian tones to the accompaniment of terrific bangs with their swords, to the imminent personal danger of their neighbours. Then the Gaudeamus is sung, and no description can do justice to the effect produced by a hundred voices, in a small room, singing at high pressure—

Pereat tristitia,
Pereant osores,
Pereat diabolus,
Quivis antiburschius,
Atque irrisores.

Vita nostra brevis est,
Brevi finietur,
Venit mors velociter,
Rapit nos atrociter,
Nemine parcetur.

Vivat ars gymnastica
Nunquam descenescat.
Vivat et gymnasticus
Chorus academicus,
In aeternum crescat.

This finished, the president empties his glass at a draught, and "Colloquium" is called. You are now again at liberty to chat and smoke—but not a pipe, pipes being only allowed when the official part is over. But not for long. The president rises again, the bangs are repeated, and another song is sung. The songs of the "official part" are all excellent: some of them, like "*Der Gott der Eisen wachsen liess*" or "*Wenn alle untren werden*," are relics of the stern times of the Napoleonic wars; others, like "*Es braust ein Ruf*," and "*O alte Burschenherrlichkeit*," with its catching refrain—

O jerum, jerum, jerum,
O quae mutatio rerum!

are of national celebrity. Then the president reads a list of the old gentlemen and guests present, each name being greeted with more or less acclamation according to the popularity of the owner, and empties his glass to their health. There is a further pause, and again a song. A Fox comes forward, supported by another to act as prompter, and proposes the health of the Alte Herren in a speech which is received with roars of laughter. Everything is done to make the poor Fox, already nervous and stammering, more distracted still, and, sad to say, the old gentlemen are the foremost in their good-natured chaff. Then more talk, more songs, and the senior old gentleman rises, responds to the toast, drinks to the prosperity of the association, lectures the members in a

fatherly manner, draws attention to the "political situation," goes back to old days, and calls for three cheers for the president. At half-past eleven the official part is over, and the "Hospiz and Fidulitat" part commences. The president vacates his seat, which is taken by a member in plain clothes, the members produce pipes, and the fun waxes fast and furious. Songs, no longer grave, but some, like the risible narrative of Count Rudesheim, excellently suited for a smoker, are sung, and more handfuls of paper tickets are needed. Bit by bit the members drop out, but the most convivial keep things lively till well into the small hours. Such gatherings are exceedingly interesting, and they are far from being drunken orgies, although a large amount of beer is necessarily consumed. The guest need not drink more than one glass so long as he stays, nor in fact need anybody—except the poor Fox. There exists an absurd regulation which enacts that members must respond to each other's pledges. The full member or guest when "pledged" need only raise his glass to his lips and take a sip, following the Jacobite custom, but the poor Fox, when pledged by a member or guest, has to empty his glass. The result may be imagined when one remembers that the German student is as keen on "larks" as anyone. It is, therefore, no rare thing for the "funny man" to fix a Fox with his eye and pledge him every five minutes, until the junior literally floats in beer. Specially interesting are the relations of the old gentlemen to the younger members. All stiffness is laid aside in the Kneipe, for all are on the same level. At the first meeting I attended I was the guest of the professor of surgery and among the members were two of his assistants who, I was scandalised to hear, instead of deferentially styling him Herr Professor, called him familiarly "Longshanks" (his Kneipe name), while he himself referred to them as "Cyclops" and "Tum-tum" respectively. A party of old gentlemen, when they meet, refer to one another exclusively by their Kneipe names, and the value of the clubs as a bond of union and promoters of good fellowship can hardly be over-estimated. An impressive and solemn ceremony, entirely different from the convivial gathering just described, is a *Trauer Salamander*. When a member dies, the association meets as soon as possible after the funeral, at the usual beerhouse. Members are dressed in black, the club flag is draped, and the president keeps his huge hat in his hand. The Gaudeamus is solemnly sung, and the president calls for the usual honours to the dead. Each man takes his beer mug, and moves it thrice upon the table, grinding it so as to produce a rubbing noise. Then the mugs are emptied at a draught, and dashed to pieces on the floor. Not a word is spoken, but the members file out in silence, the president, still uncovered, bringing up the rear.

At each of the Austrian universities there is a professor of fencing, who gives regular demonstrations. The Burschenschaften, however, have their own fencing masters, as each corps possesses certain secret parries or cuts. Where the members fight with each other, the affair is quite unromantic, only the cheeks, forehead and nose being exposed, and a slight cut being sufficient to end the matter. Heavy cavalry swords or Schlägers are used; only cutting being allowed. Where a member fights with a member of an opposing or non-affiliated corps it is usually an affair of honour, and the severity of the proceedings depends on the degree of the insult. When your mother, sister or female cousin has been insulted you may claim to fight *à outrance*, and your challenged opponent, who has the choice of weapons, must choose pistols or swords. If he chooses pistols, comparatively little damage may result, but if swords are taken the matter becomes very serious. The opponents fight stripped to the waist, and the encounter goes on till one of them is unable to fight any longer. At one Austrian university two students were killed in such duels during last winter term; at the German centres, however, such extremes are much rarer. When your male relations, or you yourself, have been insulted, you can only in very rare cases (where the insult is exceptionally grave), claim to fight totally unguarded. Usually you must allow your opponent a neck and an arm guard. With a civilian (that is, one who is not a member of the university) you cannot enforce a duel; if challenged by him, however, you cannot refuse a meeting. With an army officer, you can enforce a meeting, bearing in mind that the affair is doubly serious because he is allowed to thrust, being accustomed to the Italian school. What happens if your opponent adopts the Spanish rapier play it would be difficult to foretell; there are no precedents. Usually rapiers are discountenanced, though officially they are allowed. If challenged, and you refuse to fight, your case is referred to the committee, who judges upon it, and if it is found that the challenge has been a fair one, you are proclaimed *ehrlos* (dishonoured) and expelled. This means ostracism, academically as well as socially, in Austria at least; but abuse of the duelling system is largely (though not entirely) prevented by the committees, who take all aspects of every individual case into consideration. If you are a very expert swordsman (as the president always is) you are free from challenges; if a foolish junior calls you out, you may content yourself with showing your skill by just nicking his left cheek at the first pass and refusing to proceed with so obvious an inferior.

Vienna, June, 1908. C. L. L.

Sport.

The following Blues and Half-Blues have been awarded:—

Cricket.—Blues: P. C. Charlton, R. Montgomery, C. H. Medlock, J. H. Clapperton, H. Lee, A. H. Birks. Half-Blues: W. E. S. Digby, N. E. Farr.

Athletics.—Blues: H. Tucker, R. M. King, H. N. Eccles. Half-Blues: H. Renton, F. S. Adams.

Lawn Tennis.—Half-Blues: R. Curle, A. S. Roe.

Swimming.—Half-Blues: C. D. Roberts, G. B. Pritchard, A. Moberley, H. G. Rice.

Shooting.—Half-Blue: W. E. Wallis.

Football Fixtures, 1908-9.

Rugby.—First Fifteen.

1908.			
Oct.	3	London Devonians	Home
	10	Catford	Away
	17	Rosslyn Park	Away
	21	Cambridge University	Home
	24	U. C. S. Old Boys...	Home
	31	Lennox	Home
Nov.	7	Streatham	Home
	11	Oxford University..	Home
	14	London Welsh	Home
	21	London Irish	Home
	28	Newton Abbot	Away
Dec.	5	Northampton	Away
	12	Richmond	Away
	16	London Welsh	Away
	19	Bedford	Home
1909.			
Jan.	2	Catford	Home
	9	U. C. S. Old Boys	Home
	16	Blackheath	Away
	23	Old Merchant Taylors	Home
	27	Oxford University...	Away
	30	Plymouth	Away
Feb.	6	United Services	Away
	13	R. M. C. Camberley	Home
	17	Cambridge University	Away
	20	Old Leysians	Away
	27	Rosslyn Park	Home
Mar.	6	Lennox	Away

Rugby.—Second Fifteen.

1908.			
Oct.	3	African Banks	Away
	10	Catford	Home
	17	Old Blues	Home
	24	U. C. S. Old Boys...	Away
	31	Lennox "A"	Away
Nov.	7	Streatham "A"	Away
	21	Tunbridge Town	Away
	28	K. C. S. Old Boys	Away
Dec.	5	Rosslyn Park	Home
	12	Harlequins "A"	Home
1909.			
Jan.	2	Catford	Away
	9	U. C. S. Old Boys	Away
	16	Lennox	Home
	23	Rosslyn Park	Away
	30	African Banks	Home
Feb.	20	Harrow	Home
	27	Tunbridge Town	Away

Rugby.—Third Fifteen.

1908.			
Oct.	3	R. M. A. Woolwich	Away
	17	St. Paul's School II.	Away
	24	U. C. S. Old Boys...	Away
	31	Lennox "B"	Away
Nov.	4	Dulwich School II.	Away
	7	King's College, Wimbledon ...	Away
	14	Three Banks "A"	Away
	21	London Hospital III.	Away
	25	Tonbridge School II.	Away
	28	Rosslyn Park III....	Home
Dec.	9	Royal School of Mines	Home
	12	Harlequins II.	Home
1909.			
Jan.	2	Old Alleynians III.	Away
	9	U. C. S. Old Boys...	Away
	23	Lennox "B"	Away
	27	Royal Naval College II.	Home
Feb.	6	Blackheath II.	Away
	13	Three Banks "A"	Away
	20	Royal School of Mines	Away
Mar.	3	Royal Naval College	Away
	6	Park House "B"...	Away
	13	Sidcup "A"	Away
	17	King's College, Wimbledon ...	Away

Association.—First Eleven.

1908.			
Oct.	3	Trial Game	Home
	7	Trial Game	Home
	10	Surrey Senior Cup Tie	
	14	Emeriti	Home
	17	London Devonians	Home
	24	Lee	Away
	31	Eversleigh	Away
Nov.	7	Surrey Senior Cup Tie	
	14	Lee	Home
	21	Wanderers	Away
	28	Old Citizens	Home
Dec.	2	Casuals	Home
	5	Old Malvernians	Home
	12	Beckenham	Away
1909.			
Jan.	2	Eversleigh	Home
	9	Surbiton Park	Home
	13	Old Felstedians	Home
	16	Beckenham	Home
	30	Surbiton Park	Away
Feb.	3	Casuals	Home
	6	Croydon Park	Home
	10	R. M. A.	Away
	13	Marcians...	Home
	20	Weybridge	Away
	27	Old Tollingtonians	Home
Mar.	6	Ramsgate	Away
	13	3rd Kent Artillery...	Away

Association.—Second Eleven.

1908.			
Oct.	3	Trial Game	
	7	Trial Game	
	10	Surrey Junior C. T.	Home
	24	Old Citizens "A"	Home
	31	Old Westminsters "A"	Home
Nov.	7	London County Asylum	Away
	14	Surrey Junior C. T.	
	18	St. John's Hall	Away
	21	East London College	Home
	28	Wanderers "A"	Away
Dec.	5	Middlesex County Asylum	Away
	12	Beckenham "A"...	Home
	19	Kenley	Home
1909.			
Jan.	9	Surbiton Park "A"	Away
	16	Beckenham "A"	Away
	20	Hampstead "A"	Home
	23	Croydon Park	Home
	30	Surbiton Park "A"	Home
Feb.	3	Middlesex County Asylum	Away
	13	Kenley	Away
	17	St. John's Hall	Away
	27	Old Tollingtonians "A"	Away
Mar.	6	3rd Kent Artillery "A"	Away
	13	Shenley	Away
	20	East London College	Away

A good many 3rd XI. fixtures have also been arranged.

Eds.—L. M. & A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

October.

Sat. 17. 1st XV. v. Rosslyn Park (Away).
2nd XV. v. Old Blues (Home).
1st XI. v. Wanderers (Home).
2nd XI. v. London County Asylum (Away).
Physical Society — Pathological Meeting, 8 p.m. (President—K. H. Digby.)

Mon. 19. Clinical Lecture by Mr. Rowlands, 1.15 p.m.

Wed. 21. 1st XV. v. Cambridge University (Home).

Thur. 22. Messrs. Dunn and Rowlands' Take-in (Mr. Hinde).

Sat. 24. 1st XV. v. U.C.S. Old Boys (Home).
2nd XV. v. U.C.S. Old Boys (Away).
1st XI. v. Lee (Away).
2nd XI. v. Old Citizens "A" (Home).

Mon. 26. Clinical Lecture by Mr. Targett, 1.15 p.m.

Thur. 29. Sir Alfred Fripp and Mr. Turner's Take-in (Mr. Syms).

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated.*

Passim.

THE Physical Society opened its session auspiciously on October 8th, with the annual dinner and opening address, delivered this year by Sir Douglas Powell, Bart., K.C.V.O., the President of the Royal College of Physicians. At the dinner, held as usual in the College dining-hall, Mr. Cosmo Bonsor was in the chair. In accordance with an excellent custom, which is steadily gaining in popularity, there were no formal speeches. The staff, including the consulting staff, was well represented, and there was a good attendance of members. Praise is due to the steward of the club for the excellent dinner and tasteful table decorations which were provided.

AFTER dinner the company migrated to the Anatomy Lecture Theatre, where Dr. Goodhart took the chair, and Sir Douglas Powell delivered the address, which we publish in full in this number. An unfortunate occurrence interrupted the steady flow of this dignified and thoroughly interesting discourse, not long after its beginning, for something went wrong with the electric lighting, and the whole theatre was suddenly thrown into inspissated gloom. Sir Douglas Powell made a brave attempt to continue the

reading of his paper by the light of a match held by one of our assistant physicians until the arrival of an oil-lamp; but he deserves sympathy for the trying circumstances under which he had to speak. These circumstances, however, in no way altered the interest and value of his address, which was called, "A Just Perspective in Medicine." Perhaps at no time in the history of medicine, more than the present, has it been so necessary to point out the importance of a just perspective. The multiplication of methods of diagnosis, of remedies, of pathological theories, has continuously increased the difficulty of seeing the wood for the trees, and of distinguishing the useful and permanent from the useless and ephemeral. Sir Douglas Powell's address ought to do a good work in enabling us to review recent medical science from the proper standpoint to obtain a just perspective.

On the same evening the usual display of books, instruments, etc., was held in the Museum. Messrs. Down Bros. and the Holborn Surgical Instrument Company were showing instruments; Mr. Grattan had on view a collection of the latest books and new editions; and Messrs. Stanley exhibited microscopes and accessories. Messrs. Ash & Co.'s stall attracted a considerable amount of interest, for they had brought down a hand-press and were demonstrating the method of printing from a photogravure plate. Copies of this portrait—which was an excellent likeness of Sir Douglas Powell—together with artistically-designed and printed programmes of the Society's session, were distributed as souvenirs of the occasion to all the members present, and were much admired and appreciated.

A pleasant surprise awaited the writer of these columns the other day when he paid his weekly visit to the box placed in the colonnade for contributions to the Gazette. No masterpiece in literature, indeed, did he find there; no product of the poet's imagination or the artist's pencil; not even an abusive letter! To find any or all of these would have been something of a surprise, but to find threepence in coppers was indeed an unlooked-for event. Whether they had been dropped there by some grateful but ataxic patron of the Front Surgery in mistake for the recognised coffers of the hospital, or whether (as we should prefer to think) they had been contributed, out of sheer generosity, to the proprietors of this journal by some enthusiastic reader, we cannot say; but we trust that the publicity given to this kind and thoughtful act will in no way deter other charitable sympathisers.

We note with interest that when Dr. Macnamara, Financial Secretary to the Admiralty, presented the prizes on the 29th of last month to the class of Naval Surgeons who are leaving Haslar Hospital, Surgeon A. T. Rivers received the Gold Medal for Naval Hygiene, and was specially mentioned for zeal and ability. At the Haslar examination, Surgeon Rivers easily maintained the first place which he held at the London examination.

There is now hanging in the Wills Library, a copy of an excellent reproduction of Mr. Herbert Draper's portrait of Dr. Frederick Taylor which is on the staircase leading to the Court room. It is thought that many of our readers will probably like to obtain a copy of this photogravure, the price of which is seven-and-sixpence. Anyone desirous of securing a copy should leave his name with the Librarian on or before the last day of this month.

The life story of the late Sir Thomas Stevenson in particular, and of medical jurists in general, continues to supply that entertaining periodical, "M.A.P.," with chatty personal paragraphs. A correspondent sends us the following cutting, which is of some interest:—

"You recognise," asked a barrister of Stevenson, when he was giving evidence, "how fraught with terrible consequences your evidence may be to the man in the dock?"

"I have nothing to do with the consequences," replied Stevenson, calmly.

"A mistake—an error—may send an innocent man to the gallows," went on the barrister, impressively; "and, with that terrible possibility before you, will you say that there is no possibility of your being mistaken, when you speak of decimals of grains being found in the dead person?"

"There is no possibility of my being mistaken," answered the witness.

Presentation to Mr. Newland-Pedley.

On the 1st inst., an illuminated address on vellum was presented to our Consulting Dental Surgeon.

The names of the subscribers, eighty-two in number, were appended to the address, which read as follows:—

"To Frederick Newland-Pedley, Esquire, F.R.C.S., L.D.S. Eng., Consulting Dental Surgeon to Guy's Hospital. We, the undermentioned colleagues and Dental students of Guy's Hospital, ask your kind acceptance of the sum of £205 6s. 9d., subscribed for by us for the purpose of establishing a Gold Medal for Practical Dentistry, as a permanent record of your valuable services to Guy's Hospital and Schools. We greatly appreciate the zeal and energy you displayed in the foundation of Guy's Dental School, your ability as a lecturer and teacher, and your skill and devotion to the hospital during a period of twenty-two years, namely, from 1885 to 1907. It is our earnest hope that you may long be spared to enjoy continued prosperity and good health."

It may be mentioned that the first medal has been presented to Mr. Newland-Pedley by his dental *confrères*, and that the award will be made annually to Dental students. The medal is of excellent design and workmanship, the obverse bearing a finely-executed medallion portrait of the founder, and on the reverse are displayed the arms and motto of Guy's Hospital.

Dental News.

A Meeting of the Dental Society was held in the Physics Theatre on Friday, October 9th. Mr. Spiller, the newly-elected president, was in the chair, and gave his inaugural address, which we shall have pleasure in publishing in our next issue.

The Society then proceeded to the election of a member to represent the May, 1908, entry on the Committee; Mr. A. J. Poock, B.A., was elected.

It was announced that the October entry would elect their representative at the next meeting of the Society.

Casual communications were then presented as follows:—

Models showing a transposition in form between the first and second lower molar on each side, the first molar having four cusps and the second five.

Mr. S. W. Charles.

Two models showing palatal abscess, in the one case arising from an upper left lateral incisor, in the other from the palatine root of an upper right six-year-old molar. Mr. F. N. Doubleday.

The President then called on Mr. S. W. Charles to read his paper on "Artificial Crowns." Mr. Charles, in a bright and interesting paper, strongly recommended the æsthetic and practical value of porcelain crowns, especially of those made with tube teeth.

In the discussion which followed, the President and Mr. Malleson, with Messrs. Hedley Visick, E. E. Solomon and Griffin, took part. A strong feeling that banded metal crowns were of utility was expressed.

Fifty-three members were present.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Newland-Pedley Medal.

Dear Sir,—Will you allow me, through your columns, to thank the subscribers towards the Gold Medal that is to bear my name. When Mr. Maggs informed me of the project, I did all I could to stop it, for I thought that whilst the Dental School existed I should be remembered; but I see the matter now in a different light, and accept with great pleasure the first impression. I think it is a very nice medal, and am vain enough to believe that the likeness is good; and I do not doubt that it will be the means of doing a great deal of good, for in this case the one man who receives the distinction does not shut the door against all those who follow. The most junior practitioner in the most distant village, working single-handed, can do just the same work that I did, and perhaps he will do it better. He will meet his reward, even if he does not get a medal. In my early days I should have been quite satisfied with a plaster of Paris bust, and it must be remembered that I had an exceptional opening, in a great hospital, aided by men stronger than myself, and above all I had good luck.—I am, dear Sir, yours sincerely,

F. NEWLAND-PEDLEY.

Hampstead,
October 2nd, 1908.

Dental Education.

Dear Sir,—I have read with interest the paper on Dental Education, by Mr. H. G. Spain, and quite agree that much might be altered.

Dental students have a wide area to cover, and considering the short educational period, no doubt a good deal of the existing syllabus might with advantage be exchanged for more practical work. I should like, however, to add just a word with reference to leaving too small a margin to one's knowledge, for the specialist (dental or otherwise) whose learning is confined within the narrowest possible space must of necessity view all cases through limited glasses. With a short period for study, by all means get to know as much as you can of your particular subject; but there are things other than tapeworms (one of the examples selected by Mr. Spain), where a more general knowledge would be of decided advantage.—Yours very truly,

A. LEIGH ALLWORTH.

Sydenham,
October 3rd, 1908.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. T. F. Brown (Dr. Hale White); H. I. Shahin (Dr. Pitt); A. H. Crook (Sir Cooper Perry); C. F. Searle (Dr. Shaw).

Clinical Assistant in Surgical Wards.—Mr. E. P. L. Hughes (Mr. Dunn).

Ophthalmic Dressers.—(Nov. 1st) Messrs. K. H. Hole, H. R. Bastard (Mr. Eason); A. C. Schulenberg (Mr. Ormond); (Dec. 16th) R. A. Rankine, A. D. Williams (Mr. Ormond); H. L. Duke, L. W. Evans (Mr. Eason).

Surgeons' Dressers.—Messrs. W. E. Williams, H. L. Attwater, R. P. Ballard, T. J. Killard-Leavey (Mr. Symonds); N. L. Reader, W. H. Watson, F. S. D. Berry (Mr. Lane); G. H. Peall, C. C. Tudge, M. A. E. Duvivier, C. Witts (Mr. Dunn); D. A. Mitchell, B. McDermott, W. Reynolds (Sir A. Fripp).

Obstetric Dressers.—(Nov.-Dec.) Messrs. C. C. Holman, J. Lee Atkinson, A. L. Fitzmaurice, G. F. Haycraft (Dr. Horrocks); A. A. Greenwood, N. A. D. Sharp, A. H. G. Burton, W. S. Kidd (Mr. Targett).

Externs.—(Nov.) Messrs. M. M. Adams, E. L. Elliott, F. C. Endean, L. W. Evans; (Dec.) H. Platts, H. Steinbach, F. D. Saner; (Jan.) N. A. D. Sharp, A. L. Fitzmaurice, W. S. Kidd.

Civil.

Howell, John, M.B., B.S. Lond., F.R.C.S. Eng., has been appointed Medical Officer, Cheltenham College.

Reid, Edgar, M.R.C.S., L.R.C.P. Lond., has been appointed a Medical Inspector of Schools for Swansea.

Thomas, Jabez, F.R.C.S. Eng., L.R.C.P. Edin., L.S.A., has been appointed a Medical Inspector of Schools for Swansea.

Military.

ROYAL ARMY MEDICAL CORPS.

The undermentioned to be officers whose services will be available on mobilization:—

2nd Northern General Hospital.—To be Lieutenant-Colonels: T. Churton, M.D., and A. G. Barrs, M.D. To be Majors: R. L. Knaggs, M.D., F.R.C.S., and W. H. M. Telling, M.D.

5th Northern General Hospital.—To be Major: Astley V. Clarke, M.D. To be Captains: R. Michel, R. Hilton Fagge, and R. Basil Stamford, F.R.C.S.

1st Southern General Hospital.—To be Major: J. T. J. Morrison, F.R.C.S.

2nd Southern General Hospital.—To be Major: R. G. Poole Lansdown, M.D. To be Captain: J. M. Fortescue-Brickdale, M.D.

Notices.

Royal College of Surgeons of England.

Notice is hereby given that the next Primary and Final Examinations for the DIPLOMA of FELLOW will commence on Thursday, Nov. 5th, and Friday, Nov. 20th, 1908.

Candidates are required to give not less than fourteen days' notice of their desire to present themselves for either of these Examinations.

Particulars relating to these Examinations may be obtained of the Secretary (Mr. F. G. Hallett), Examination Hall, Victoria Embankment, London, W.C., to whom all applications in reference to Examinations should be addressed.

The required Fees must be paid three days prior to the Examinations.

Sept. 17th, 1908.

LICENCE IN DENTAL SURGERY.

OLD REGULATIONS.

Notice is hereby given that the next Examination will commence on Friday, Nov. 6th, 1908.

NEW REGULATIONS.

Notice is hereby given that the First and Second Professional Examinations will commence on Friday, Nov. 6th, 1908.

Candidates are required to give not less than twenty-one clear days' notice in writing of their desire to present themselves for either of these Examinations to the Secretary (Mr. F. G. Hallett), Examination Hall, Victoria Embankment, W.C., from whom all particulars relating thereto may be obtained.

Sept. 17th, 1908.

Apparatus Reviewed.

We have received illustrations and an account of the Guyot Greville Operating Table, which attracted much attention at the recent meeting of the British Medical Association at Sheffield.

The special advantages are the great variety of movements and the ease with which they are obtained; raising and lowering are obtained by a lever worked by the foot. The table is readily rotated.

The Trendelenberg, lithotomy, and other desirable positions are readily shown, and the table works easily even with the heaviest patients in position. There is, however, an entirely novel movement. By a simple mechanism the patient can be tilted to the right or left side, a great convenience in many cases.

Full particulars will be supplied on application to The Medical Supply Association, 228–30, Gray's Inn Road, W.C.

Case of Addison's Disease.

CLINICAL LECTURE BY Dr. W. HALE WHITE.

(Reprinted from the *Clinical Journal.*)

Gentlemen,—Here is a very remarkable thin quarto book, and it is one which I think ought to make us all feel proud, because much of the fame of this hospital rests upon it. It is by Addison, and on disease of the supra-renal capsules; in this small compass two entirely new diseases are described. And they are described not as the result of any experimental observation, but solely because Addison, by his power of observation, was able to make out that these two new diseases existed. I think, if you will reflect on how difficult it is to observe properly, you will agree with me that the publication of a book like this is one of the highest flights of the power of observation carried to the point of being real genius. As we have in the wards at the present time an instance of both of these diseases which are described in this book, I thought we could not do better than talk about Addison's disease this afternoon. The date of the publication of this book is, as you will see afterwards, 1855. Many years before Addison published this book, the full title of which is, "On the Constitutional and Local Effects of the Disease of the Supra-renal Capsules," he read a paper at the South London Medical Society on the same subject, and waited some years to see if his views were correct, and then he finally published this famous book. Perhaps I might read to you his account of the disease, and then we will see how far our patient fits in with it. In my own copy—because, unfortunately, the first edition, of which this is a copy, is rare, and I have not a copy myself of that edition—I will read you what he says: "The leading characteristic features of the morbid state to which I would direct attention are anæmia, general languor and debility, the remarkable feebleness of the heart's action, irritability of the stomach, and a peculiar change of colour in the skin, occurring in connection with the diseased condition of the supra-renal capsules. The patient, in most of the cases I have seen, has been observed to gradually fall off in general health, he becomes languid and weak, indisposed to either bodily or mental exertion, the appetite is impaired or entirely lost, and the whites of the eyes become pearly, the pulse small and feeble, but excessively soft and compressible. The body wastes, not, however, presenting the dry shrivelled skin and extreme emaciation usually attending malignant disease. Slight pain or uneasiness is from time to time referred to the region of the stomach, and there is occasionally actual vomiting. Notwithstanding these unequivocal signs of feeble circulation, anæmia and general prostration, neither the most diligent inquiry nor the most careful physical examination tend to throw the slightest gleam of light upon the precise nature of the patient's malady, nor did we succeed in fixing upon any special lesion as the cause of this gradual and extreme constitutional change." Then he goes on to describe the pigmentation, but that I will do when I tell you about our own patient. You see he gives a distinct clinical picture of the disease. And then the greatness of his discovery lay in the fact that he pointed out that invariably, when those symptoms were present, disease of the supra-renal capsules was found. You notice that there are three or four very important signs which can be picked out of his description, and although the pigmentation is not the first of the symptoms to appear, it is so much the most important that I thought we would take that first. I am sorry to say that I cannot bring you the patient here to-day, because in the last few days he has become much worse; it would probably kill him to bring him here. We could hardly feel his pulse this afternoon. If you will go and look at him in the ward after the lecture you will see that all over he is stained dark brown, and that here and there there are darker patches on the top of that dark brown. Addison described it as "a dingy or smoky appearance, of various tints or shades, of deep amber or chestnut brown. And in one instance the skin was so universally and deeply darkened that, but for the particular features, the patient might have been mistaken for a mulatto." And that really describes our patient as well as any words of mine. As I cannot show you the patient I have brought you Addison's original coloured pictures. The first shows a case with rather light colouring, but still it is the tint you expect to find in Addison's disease, and it is the tint which you will notice in our patient. Here is another picture of an even fainter tint. Those pictures give you a very good idea of the tint observed. There are a few points worthy of note about pigmentation. There are certain places in the body where it is darker than elsewhere. It is darker where the skin is inclined to go into folds naturally, so it is especially darker in the axilla, as shown in one of these plates. It is especially dark over the genitals. In the scrotum and in the penis against the thigh there are a good many folds of

skin and points of contact, so that pigmentation is always very dark there. And if you pull down the foreskin and look at the glans penis you will often find pigmentation there too. Our patient shows it admirably. It is often very striking on the nipples; notice how dark the nipples are on that plate which Addison published. And it may be seen especially in the flexure of the knees, and it is very dark wherever there is a band round the body, so that if a man has worn a belt he has a rather darker band round his body. Also, if a man's chest is examined, where his braces have pressed, the pigmentation will be darker there, and the same is observed where the garters have been on the legs. And lastly, it is usually darker where there are any prominences, such as acromial prominences, for instance. You may see it anywhere inside the mouth. Our patient has a beautiful patch of it on the mucous membrane of the mouth, where the upper and lower lips meet. You may see it on the palate in some patients, and even on the tongue. It may very rarely be seen under the nails. Pigmentation has also been observed under the conjunctiva, but I have not seen it there. People become pigmented from many different causes, and probably all of you have seen cases in which the diagnosis of Addison's disease has been discussed, and it has been difficult, perhaps, to come to an opinion at first sight, and so I thought it would be practical if I mentioned to you the fallacies. I think perhaps the most common fallacy is to mistake Addison's disease for pernicious anæmia, which is the other disease described by Addison in this work which I have shown you. Pernicious anæmia, you know, is a disease in which there is excess of blood destruction, and we have evidence of its destruction in the deposit of free iron in the liver, and also in the large amount of urobilin which is excreted in the urine. In that disease the skin goes a peculiar lemon tint, probably being stained by some of the products of the abnormal blood destruction. This yellow staining is quite different from the characteristic case of Addison's disease, but in slight cases confusion often arises. Nowadays confusion could hardly arise if you had the patient under protracted observation, because examination of the blood in Addison's disease shows very little abnormal, and examination of the blood in pernicious anæmia shows you that there is a very considerable degree of poikilocytosis, and there are megaloblasts, there are nucleated red cells, and the colour index is raised. But let me here again remind you, as I am so often reminding you at the bedside, that you must not be content with negativing the diagnosis of pernicious anæmia because a single blood examination does not show the characteristic changes. The blood in pernicious anæmia varies much from day to day and hour to hour. And often you cannot make a diagnosis of pernicious anæmia on a single examination of the blood only. But if you are able to make several examinations there is no difficulty in distinguishing between pernicious anæmia and Addison's disease, quite apart from the colour, which, indeed, is usually quite different in the two diseases, lemon-yellow in pernicious anæmia, dingy-brown in Addison's disease. Another disease about which there is often great difficulty is to tell whether a patient has Addison's disease or whether he has had his skin stained as the result of prolonged administration of arsenic. You will, I am sure, agree with me that that difficulty frequently turns up in the wards, and some of the senior men here may remember that a year or two ago there was in the hospital under my care a man who was very considerably pigmented, and there was a constant discussion as to whether or not his pigmentation was due to Addison's disease, whether or not it was due to arsenic, or whether it was due to pernicious anæmia. You will remember that the point of interest about that man was that he had some pigment patches inside his mouth. At the time I did not know whether or not the pigmentation of arsenic could ever occur inside the mouth, and we left the matter in doubt; but we came to the conclusion from the examination of the blood—and it is of interest that in only some of many examinations made by Mr. R. W. Allen were the characteristic changes of pernicious anæmia seen—that he had not Addison's disease, but that he had pernicious anæmia, and we were unable to say whether the pigmentation in the mouth was due to his pernicious anæmia or to his arsenic. I took the case before the Association of Physicians of Great Britain and Ireland, which met in London last spring, and fortunately some members present had worked at the outbreak of arsenical poisoning in Manchester, which followed drinking beer impregnated with arsenic. And then I learnt that those who had had such a large experience of arsenical poisoning had never seen a case of pigmentation of the mucous membrane of the mouth through arsenic, and I was therefore driven to infer that the pigmentation in that case was due to pernicious anæmia. But otherwise the pigmentation of arsenical poisoning is very like that of Addison's disease. But remember that the occurrence of pigment in the mouth will be a great point in favour of the

case being Addison's disease. Here I show you a picture of arsenical pigmentation, and you will see how similar the tint is to that of Addison's disease. Another cause of difficulty sometimes met with is, at first sight, to tell the pigmentation which people get who have malignant disease from that which occurs as a result of Addison's disease. But that really ought not to bother you long, because a patient with Addison's disease is not so excessively wasted as is the patient with malignant disease, and in the latter case you will usually find evidence of malignant disease somewhere in the body. Again, in the filthily dirty patients whom you see in hospitals, and who are infested with lice, there is a pigmentation of the skin from the chronic irritation, but that ought not to give rise to much difficulty. Occasionally you see phthisical people with pigmentation of the skin, but there the signs of phthisis are obvious, and that will not cause difficulty. Sometimes after a patient has had syphilis there is a certain staining of the skin, a brown discoloration from the old syphilitic eruption, but I have not seen that give rise to any serious difficulty in diagnosis. And then there is that excessively rare disease, Hanot's cirrhosis of the liver, which is easily detected, with slight jaundice and a big liver, and although the skin is pigmented in that it can give rise to no difficulty. And there is that rare disease called "bronzed diabetes," of which I have only once seen an example, in which there is diabetes. But the presence of sugar in the urine will get you out of your difficulty in the matter. The text-books also include the pigmentation of pregnancy, but I have not heard of that being mistaken for Addison's disease. So the differential diagnosis really comes down to this: Has the patient Addison's disease, pernicious anæmia, or arsenical pigmentation? In the last case you have a history of his having taken arsenic, there is the examination of the blood for pernicious anæmia, and so you ought never to go far wrong in the matter. But the difficulty is greater than it seems, because you will meet with patients in the hospital who have been taking arsenic in large quantities at the out-patients' for pernicious anæmia. So much for pigmentation.

The next sign we will speak of, which is the first sign to be detected in Addison's disease, or rather what the patient first complains of in Addison's disease, is an uncontrollable sense of fatigue. Our patient in the ward now has it. We have been looking at him this afternoon. He bitterly resented being disturbed in any way; it wearied him even to turn him over in bed. He is very weak and prostrate, and you will remember that Addison said that the pulse is small and feeble, excessively soft and compressible. The only way in which we have added to Addison's description, as far as the weakness goes, is that we have of late been taking the blood-pressure with a manometer, and his statement that the pulse is small, feeble, and excessively soft and compressible has been amply borne out by the manometric readings. Dr. Mann has been kind enough to take several readings from our patient in the hospital, and the blood-pressure on the whole has been consistently sinking ever since the man has been in. Here are the readings which Dr. Mann kindly supplied. There are many readings below 60. When the patient came in his maximum systolic pressure was 70, his mean systolic pressure 65, and then, shortly afterwards, the maximum was 65 and the mean 60. It went up a little then, and he seemed to improve, but lately it has gone back very much indeed, and yesterday the lowest pressure had been reached which has been recorded, for the maximum systolic pressure had fallen to 48. That is the lowest pressure Dr. Mann has ever taken, although he has taken so many. And so we have confirmation in figures of Dr. Addison's statement about the smallness and weakness of the pulse. The reason why that should be so I will tell you directly. If you will go into the ward and look at the man you will see that what Addison says is true, that the body wastes without presenting the dry shrivelled skin and extreme emaciation seen in malignant disease. These patients do get thinner, but the wasting is not a prominent feature, and as far as I have seen these patients never get to look like a patient with severe malignant disease. Although they are losing flesh they lose it more slowly than cases of malignant disease do, and the skin never becomes dry and shrivelled.

The last point I mentioned to you that Addison described is that there is slight pain or uneasiness referred from time to time to the region of the stomach, and there is occasionally actual vomiting. That is so in our man. He complains of considerable pain and vomiting. We had him up the other day, but he said he would go back to bed because he felt pain and was sick. There are not many diseases which have fewer symptoms to describe than Addison's disease, and I have already told you all. It is the fewness of the symptoms which prevents this subject being set in examination papers, but that does not make it any the less interesting. Further collections of cases since Addison's

death have given us an idea of numerical proportion. It is commoner in men than it is in women, for 65 per cent. of the cases are males. Everyone is agreed that it is very rare in the young and in the old. These patients are usually between 30 and 60 years old.

The greatness of Addison's discovery did not lie so much in the discovery of the disease as that he predicted what would be found if a post-mortem was made. He predicted that disease of the supra-renal capsules would be found. Here is a plate from his work showing the diseased capsules. You will see that the supra-renal capsules have each become converted into an enormous caseous mass. I have brought down many specimens from the Museum; we are very rich in such specimens at Guy's. Here are two huge supra-renal capsules on the top of the kidneys, from a patient with Addison's disease, and they have each been converted into great caseous masses, and I will now pass round many specimens showing the same thing. Of Addison's original cases, which were eleven in number, five showed caseous tubercle in both supra-renals, one showed caseous tubercle in one supra-renal, one showed cirrhosis and atrophy of the supra-renals—and I have brought and now pass round a specimen to illustrate that condition—and three were examples of secondary malignant disease of the supra-renal, and one, his eleventh case, was a very interesting one; a thrombus had affected the vein going to the supra-renal body so as to lead to impairment of function of the supra-renal body. In this plate in his work you can see the thrombus projecting from the supra-renal vein. Now, to tell you a little more in detail about the changes to be found after death. All collectors of cases are agreed that by far the most frequent thing found post-mortem in patients with Addison's disease is that the supra-renal bodies are the seat of chronic tubercle which has gone on to caseation. And we have no doubt that our patient is tubercular, because he has several scars on various parts of his body showing the seats of old tuberculous abscesses. Some tuberculin was put into one eye, and the characteristic reaction known as Calmette's reaction was obtained. In this method of trying to find out if a patient has tubercle, two drops of tuberculin in a 0·5 per cent. solution are dropped on to the conjunctiva of one eye, near the inner canthus, and the lids are held apart for two or three seconds. In a few hours, if the patient is a tuberculous subject, the conjunctiva becomes reddened and there is an overflow of tears on to the cheek; in a few more hours the reaction reaches its maximum, and by the end of forty-eight hours it has subsided. The other eye is unaffected, and neither eye is affected if the patient is not a tuberculous subject. No harm follows. Dr. Eyre has had a very large experience and has never seen any. The test is not infallible, but it is extremely valuable. Our patient's opsonic index to tubercle was a little below normal. It was not so much reduced for the reduction to be of much weight in itself had it not been that the other signs of tubercle were so striking. It was 0·85. Please remember that you will frequently find, often in the lungs or bones, evidence of tubercle in Addison's disease. Addison himself thought that malignant disease of the supra-renal capsules would cause the disease. Then a wave of opinion sprang up which taught that the change in the supra-renal capsules in Addison's disease must be a caseous tuberculous change; but Addison had a wider conception, and thought that any disease which impaired the functional activity of the supra-renals would cause the disease that bears his name. He believed the supra-renal bodies poured something into the blood, and that anything which destroys them will prevent this something getting into the blood, and hence the disease. And he has turned out to be correct, because we now believe and know that any lesion of the supra-renal will, if sufficiently extensive, produce Addison's disease, whether it is tubercular disease or malignant disease. All his eleven cases were undoubted examples of Addison's disease, yet several, as you have just seen, were not examples of tubercular disease.

The next point I want to draw your attention to is the specimen in which the capsules have undergone considerable atrophy. Much discussion has been excited as to the cause of this. One thing is quite certain, that sometimes the condition of those capsules corresponds to fibrosis of the lungs, and we may fairly assume that there has been old tubercular trouble followed by fibrosis, and hence atrophy. In other cases we do not know the cause of the atrophy.

Subsequent experience has shown that the number of cases of malignant disease of the supra-renals causing Addison's disease is fewer than appeared from Addison's eleven cases. Of those, no fewer than three were due to malignant disease. But in subsequent experience it has been found that by far the greater number of the cases of Addison's disease are due to obvious tuberculosis of the supra-renals, and the number is still higher if you include, as certainly sometimes you ought, among tuberculosis the cases

in which the glands have simply undergone atrophy. You may ask why do so few cases of malignant disease of the supra-renals cause Addison's disease, for it is admitted that there are many cases of malignant disease of the supra-renals in which no Addison's disease is present? I think the reason for that is not far to seek. You must first have both supra-renals affected. And in the next place it may very well be that malignant disease will kill the patient before it destroys the supra-renals, and so produce Addison's disease. There are very few cases on record illustrating Addison's eleventh case, in which, owing to the vein going to the supra-renal being blocked, there was hæmorrhage into the gland; but it appears that acute hæmorrhage into the supra-renals may sometimes cause the symptoms of Addison's disease. You see nothing substantially has been added to the description of Addison's disease since his death, and I think that is a great monument to his power of observation. Absolutely the only clinical observation which has been added has been that we have, by a manometer, tested the truth of his statement that the pulse is small and feeble.

Not every case, in which the clinical symptoms are such that it is difficult to resist the diagnosis of Addison's disease, that has ever been published shows disease of supra-renal capsules. As a matter of fact, it is stated only 88 per cent. do. But I think that is well within the limits, because some cases may have been recorded as Addison's disease in which the diagnosis was erroneous. Sometimes the post-mortem examination may have been inefficient. And, again, you have to remember that sometimes there may conceivably be some functional disturbance of the supra-renals. Another thing you have to bear in mind is, that we do now know that cells very similar to the cells in the medulla of the supra-renals are found in several situations, for instance, in the small inter-carotid glands which we have on either side of the neck, and the coccygeal glands have chromophile cells, so-called because of the ease with which they take up chromic acid, like the cells in the supra-renals. And perhaps, very rarely, disease of these glands may cause Addison's disease, and lead to death before the supra-renals are affected. It may possibly be that when disease is found in the supra-renals, and yet no Addison's disease has been present, the cells of a similar nature elsewhere in the body have been able to form enough internal secretion to prevent the patient from having Addison's disease. When our patient dies we shall try to dissect out the inter-carotid and coccygeal glands and see if they are atrophied. Perhaps they may be, as the patient is so very ill. Further, it may be that when you find disease of the supra-renal bodies, and yet no Addison's disease is present, that the disease of the supra-renals has not been extensive enough to completely destroy the medulla of the organ.

I only want to tell you now one or two points, not clinical, which we have learnt of late. We know that the cortical part of the supra-renals is distinct from the medullary. As far as we know, disease of the cortical part of the supra-renals has nothing to do with Addison's disease. In the few cases in which tumours have been recorded as growing from the cortical part of the supra-renals, some of the patients have presented abnormality of sexual development, nearly always an extremely precocious sexual development: the genital organs are large, the hair on the pubes comes at an unusually early age. These cases are very rare, and do not interest us this afternoon. The great discovery of the last few years, in connection with the medulla of the supra-renal capsules, is that it manufactures an internal secretion, and that this secretion maintains the blood-pressure throughout the body, being antagonistic to the depressor secretion of the thyroid gland. This is a discovery which helps very much in the understanding of Addison's disease, because we can now see why, owing to the failure of the body to have enough of this substance, adrenalin as it is called, circulating through the system, the blood-pressure falls lower and lower, until finally it falls to the extremely low point of 48, as Dr. Mann has observed in our patient. And that opens up a very interesting speculation, which is quite worth working at for any of you who want to write a thesis. It has been put forward, and I think with some truth, that possibly some people, thought to die from other diseases, really die in the early stage of Addison's disease. What I mean is that, supposing a man has malignant disease of some other part of his body, and his pulse becomes feebler and feebler, and of lower tension, it is very tempting to assume that what is the matter with him is that his supra-renal bodies are failing to secrete enough adrenalin, and hence his pressure has fallen, and that contributes to his death. At any rate, there is no doubt that very often, when the pulse is of very low tension, and very feeble, it can be brought up again in clinical work by injecting some adrenalin into the circulation. We have had to do it twice in clinical ward in

the last week, and it is striking how quickly the pulse has recovered after that has been done.

The suggestion has often been made that some of the symptoms of Addison's disease, *e.g.*, the vomiting, are due to implication of the nerves of the solar plexus in the disease which affects the supra-renals, but it rests on very slender foundation, for in many cases of Addison's disease the semilunar ganglia and nerves have been shown to be quite healthy; they have been found to be affected by malignant disease without Addison's disease being present; and lastly, I know from cutting dozens of sections of the semilunar ganglia that they vary so widely within the limits of health that opinions upon abnormal histological changes in them should be received with great caution.

After the lecture I want you to go into the ward and contrast with Addison's disease the condition of the man in No. 2 bed, John ward, who has pernicious anæmia, because in the same book that Addison wrote on disease of the supra-renals pernicious anæmia is described. Addison first made the discovery of this disease, and it was while looking about and collecting cases of pernicious anæmia that he at the same time discovered Addison's disease with bronzing. He thought that anæmia was a striking feature of Addison's disease. I think that if you read his account you will see that he did not think it so striking as some other writers have considered he did, and we have learnt of late years that anæmia is not necessarily a striking feature of Addison's disease. In fact, our patient in the wards at the present moment has the normal number of red cells, and about 70 per cent. of hæmoglobin. His white cells are slightly in excess. So remember that Addison's disease does not, as a rule, present much anæmia; but idiopathic anæmia, as Addison called pernicious anæmia, which I lectured about not long ago, has very profound anæmia, and, as I said just now, you can see two patients in John ward, one with genuine Addison's disease, the other with pernicious anæmia.

The treatment of Addison's disease is very unsatisfactory. We gave our patient adrenalin both subcutaneously and by the mouth, but it did no good; in his case it did not even raise his blood pressure. It has been tried in so many cases without success that when success is reported one cannot help thinking that either the success was not permanent or that there must have been a mistake in diagnosis.

The outlook in Addison's disease is very grave; nearly every patient who has it is dead within two years of the onset of symptoms.

This patient died, and both supra-renals were found to be converted into large caseous masses.

[Note.—We have reprinted this lecture in the belief that it will be of special interest just now in view of the fact that there is at present a case of Addison's disease in Mary Ward under Dr. Hale White's care. The patient is a girl of 17, who was formerly a draper's assistant. She consulted her doctor on account of a stiff-neck, and was treated by him and advised to come to the hospital. Last November she noticed that she was becoming pigmented, chiefly on the back of the neck, and later on the face, the backs of her hands, areolæ of nipples, armpits and anterior surface of thighs. At this time, also, she suffered from a feeling of sickness in the morning, with slight attacks of giddiness and faintness. She was sick a few times last November, but not again until the time of admission. At no time has she felt any weakness or languor.

On admission the pigmentation was found to be general, but more marked at the situations already mentioned. There were also several patches of pigment on the buccal mucous membrane. The pulse was feeble, and the blood-pressure in the brachial artery was found to be 70 mm. of Hg. Nothing abnormal was found in the other systems.

Since admission some pigmentation of the fingers and two of the finger nails has made its appearance. Patient was sick once after getting up, but has otherwise been perfectly well, and getting no thinner or weaker. Calmette's ophthalmo-reaction has been tried on three occasions, in each case with a negative result. We are indebted to Mr. Browning, Dr. Hale White's clinical assistant, for these notes on the case.—Ed.]

Change of Address.

Dr. E. Clifford Beale, from 23, Upper Berkeley Street, Portman Square, W., to 73, Addison Road, Kensington, W.

Fleet Surgeon William Bett, R.N., from the Royal Hospital, Greenwich, S.E., to H.M.S. *Leviathan*, Home Fleet.

Dr. Walter Buchanan, from "Gairloch," Victoria Avenue, Surbiton, to Romney House, Hove, Sussex.

Mr. Hugh Davies-Colley, M.B., F.R.C.S. Eng., from Borough, Pulborough, Sussex, to Briarwood, Woking, Surrey. Teleph. 0172.

Mr. R. Davies-Colley, B.A., M.B., B.C., F.R.C.S., from Guy's Hospital to 24, St. Thomas's Street, S.E.

Dr. Alfred C. Jordan, from Leadenhall House, E.C., to 14, Weymouth Street, Portland Place, W.

Mr. Owen Richards, M.Ch., F.R.C.S. Eng., from Chareh el Cherifein, Cairo, to 9, Chareh Kasr el Nil, Cairo.

Mr. Hedley Visick, L.D.S., from 115, Harley Street, W., to 39, Brook Street, W.

Pupils' Physical Society.

Opening Meeting.

The Winter Session of the Students' Physical Society was inaugurated on Thursday, October 8th, by a dinner, at which the special guest was Sir Richard Douglas Powell, Bart., K.C.V.O., the President of the College of Physicians. After dinner an adjournment was made to the Anatomical Lecture Theatre, when Sir Douglas Powell delivered his promised address on "A Just Perspective in Medicine." The chair was occupied by Dr. J. F. Goodhart.

The Chairman said: Gentlemen, before we begin the strict business of the evening, I think, perhaps, I may fitly wish this old society "Many happy returns of the day." The older members of this society are well pleased indeed to see that it retains its ardour still, and that it has the characteristics of perpetual youth. I think, also, we may very well wish to-night, with somewhat sad regret, happy returns of the day to our dear old president, Sir Samuel Wilks. I shall have the great pleasure—but I think it will be more convenient at the end of the meeting—to read to you a letter which I have received from him to communicate to you. In the meantime we are all thankful, no doubt, to feel what a marvellous power of recuperation is possessed by him at his venerable time of life. And also, with an even better gratification, we are pleased to think what a power of influence over disease and decay has been attained by his medical advisers and by medicine and surgery in general in the last few years. It seems to me that in finding Sir Samuel Wilks restored to life, and even—as it seemed to me when I saw him a few weeks ago at Eastbourne—restored to health, that we are coming nearer to what the world has longed for, an elixir of life, and that ere long we may even expect to see—as I honestly expect to see—in our chemical laboratories, or in some form or another, to be presented by our scientific observers with some fluid, not far removed from electrical fluid, or something of that kind, which shall be able to revivify dead bones. And if not that, I think at any rate we may say that for the present much has been done to bring again the mythical old age of bygone years. Quite honestly and sincerely we, as a society, can wish to-night to Sir Samuel Wilks that he may have many happy years in store. (Cheers.) And I think my colleagues will expect me to wish you many happy returns of the day; but as I utter the words I bethink me that there used to be a gentleman who lurked about some hospitals—not, I hope, Guy's—who was called "a chronic"—(laughter)—and if I were to wish you many happy returns of the day, it might seem to suggest that that gentleman should come to our sheltering arms. Therefore, I think it will be more fitting for me, and more agreeable to my colleagues, if I wish you a reasonable number of happy returns. And I think we can all be sure that they will be very happy years. I wish, further than that, that when your time here is ended you will have acquired a new lease of life, which I hope you will have power committed to you to transfer to those with whom you are in future to be associated. Therefore, gentlemen, we may wish ourselves all round many happy returns of the day. (Applause.)

I now pass to the strict duties of the evening, and those are no less than to ask our distinguished visitor to-night, Sir Douglas Powell, President of the College of Physicians, who has undertaken, of his great kindness, to come down and talk to us to-night, to address you. (Cheers.)

ON A JUST PERSPECTIVE IN MEDICINE.

Sir R. Douglas Powell said: It is now some fourteen years since, at Torquay,* I dealt with the subject of my present discourse, and when your President and Council did me the honour to invite me to address you to-day, it occurred to me that it might be of some interest—both to my audience and myself—if I were to revert to the subject, seeking further illustrations in the light of much that has happened since in the way of medical developments. I then defined what I meant by a right perspective as being a perception of matters under immediate scrutiny or contemplation in their due proportion to other associated matters and thoughts within the same field of view; for perspective in one sense—perhaps not the most usual one—means an appropriate relation of parts to one another and to the whole view or subject.

The gift to see things in their due relationship with other things is possessed by but few people, and it is not a little curious to observe how in politics, religion, science, and even art, persons lose their sense of perspective as they become engrossed in the study of one special department or aspect of things. The State wisely recognises this weakness of human nature even in the great, by adopting the apparent anomaly of putting men of general affairs rather than specialists in control of departments, men of business rather than soldiers or sailors at the head of the War departments, a brilliant man of letters at the head of the department for India, and anyone rather than a schoolmaster to superintend education. So in medicine or surgery it is wise that every specialist should have an assessor, and the force of this last remark gathers momentum of application with the increasing number and profoundly increasing complexity in technique of the specialities in practice and research that have developed in our great science of medicine within recent times.

At the time of my previous address the use of the clinical thermometer had long been established, indeed, the instrument had already become a part of the average household equipment. In the eyes of the public the temperature in all active diseases had become the objective of attack and defence, the criterion of hope and fear, the pulse and respirations were registered in comparatively

*A Right Perspective in Medical Thought and Practice.—*Lancet* October 20, 1894.

obscure corners of the chart, written in small print, and one noticed a growing disposition in students to neglect to feel the quality of the pulse, or to note the characters of the breathing, leaving them rather for the nurse to record, and merely glancing at them when inspecting the temperature so boldly outlined on the chart. How few practitioners, indeed, there are who have acquired the art of accurately gauging the arterial resistance, cardiac power and reserve vitality, and much else that may be learned of the patient by the characters of his pulse. Like many other quotations, "The hand of little employment hath the daintier sense"* has no meaning outside its context, and particularly does not apply to medicine. I am glad to see a growing tendency, which I think we owe to the abdominal surgeons, to render in equivalent lines temperature, pulse and respiration. It at least broadens the view of the case by recording the three great indices of clinical medicine, to be analytically read and examined in the light of experience and in perspective with all other conditions.

With the importance that was attached to every movement of the thermometer, there could be little wonder that measures were soon discovered—in the use of synthetic remedies—that should lower its records. Antipyrin was one of the first of such drugs which had the brilliant and obvious effect of lowering the peaks of temperature. Even with our imperfect insight at that time into the real meaning of fever temperatures, there was still a want of perspective in our reading of and attacking such temperatures. We knew better, but were obsessed on the one hand by a magnified importance assigned to mere temperature; and on the other, by the inadequately appreciated efficacy of a new class of remedies. It was about that time that hyperpyrexia, with its fatal consequences, had gained hold upon the professional mind, and thus one way and another, practitioners got into the habit of chasing the temperature round the dial with antipyretic remedies. I ventured, at the time I am speaking of, to point out that "recent, and as yet, not fully disclosed pathological researches give a new interpretation to some pyrexial phenomena, which the thermometer but faithfully records, and are shedding a new light upon the natural history of pyrexial diseases. Thus the interesting stories, which—some of them, perhaps, fables—come to us from our Bacteriological laboratories, of the loves and antipathies, the triumphs and disasters in the microbe world, assume a new and strange fascination for us, as we come to recognise ourselves, our blood and tissues, as forming more and more largely their playgrounds and battlefields." The story of microbic action in specific diseases has year by year grown in incident and importance, and presents to us chapter upon chapter of surpassing interest.

The fact was then well known, that the organisms specific to most of the acute diseases—tubercle, anthrax, pneumonia, influenza, enteric fever and perhaps rheumatism—germinated at or above blood heat, and that their multiplication was retarded or arrested, although they were not killed, at the higher degrees of fever, about and above 104°, and it seemed to me that the tendency in practice was to pay too much attention to the higher excursions of the thermometer, and to ignore, or even to seek to bring about low ranges or deep depressions, as salutary or of negative importance. This view was growing upon many physicians after three or four years' experience of disastrous epidemics of influenza, and Dr. Hale White particularly gave the weight of his authority in favour of the same warning. Every febrile disease has a temperature of its own. Pyrexia is, indeed, a normal reaction to toxic invasion, and a rise of temperature is a symptom as proper to certain diseases as a normal temperature is to health. Antipyretic remedies should therefore be used to moderate those degrees of temperature which are dangerous to the integrity of the nervous system, heart and kidneys, not with the aim of giving a sub-normal range to a pyrexial disease.

The demonstration by Cohnheim, in 1867, of the important part taken by the leucocytes in the process of inflammation, which had, I believe, been already inferred by Addison a quarter of a century before, was a great addition to the cellular pathology of Virchow which prevailed in those days, and as some of you remember, Cohnheim's views on the migration of leucocytes caused no little commotion amongst those who had abandoned the antecedent exudation theories in favour of cell multiplication in the parenchyma or alveolar or intercellular tissues in inflammation and in growths. The brilliant discovery, many years later, by Metchnikoff of the phagocytic function of the leucocytes gave a new significance to their migration towards centres of irritation which Cohnheim had demonstrated. More recently still the equally brilliant work of Sir Almroth Wright has disclosed certain opsonic powers in the blood serum which aid and encourage phagocytic action.

Even to-day, however, if we are asked why a toxin produces fever, we can only answer, because it is a poison acting upon the thermic centres through certain channels, and if, again, the question is put why certain leucocytes attack bacteria, we can only say they are living beings, and "'tis their vocation" to go for the foreigners more or less like trout for the May fly! The fact that leucocytes press towards local centres of inflammation which are invaded by bacteria is a part—the very first line—of the old story, "ubi irritatio ibi fluxus," with all the additional meaning which modern pathology reads into it.

And when, finally, we inquire of the blood in what consists its opsonic power, we are more than ever nonplussed, and call to mind the witty simile used by a certain learned body who, in discussing with Dr. Martinus Scriblerus the nature of self-consciousness, which resides neither in the fly, nor the weight, nor the wheel, but is the result of the whole composition, compared it to the "meat-roasting quality of a jack." I ventured to ask, in reviewing the first discussion* on tuberculin treatment

*Hamlet.

*Trans. Roy. Med. and Chirurg. Society, vol. lxxxix. p. 117.

as regulated by the opsonic index, whether any chemical researches had been undertaken to ascertain the nature (chemical, I presume), of this opsonic quality in the serum. I did not meet with an encouraging response, and I am not aware that any special inquiry has been made into the matter. Is it a property of the serum or a secretion added to it from the cellular elements of the blood? The latter seems the more probable, viz., to continue our simile, that the "meat-roasting quality" adapted for each particular bacillus is yielded by the vital action of the phagocytes—that these little spitfires do indeed secrete something into the serum that obsesses their prey, and renders it more amenable to absorption and digestion. Messrs. Shattock and Dudgeon (Proc. Royal Society, B, vol. lxxx, 1908, p. 169) apparently assume opsonin to be a particulate substance capable of adhesion to and removal from the serum by inanimate matter such as melanin. But, although speculative, the view I have suggested seems to me most in accordance with the trend of opinion to which we are drawn by the work of Wright, and the side lights cast upon it by the researches of Strangways, Shattock, and many others.

Natural and acquired immunity to specific diseases has for ages been a matter of knowledge from observation. The great Jenner at the end of the 18th Century was the first to give it any specific meaning and to utilise it to any specific purpose, although it was practically accepted in the time of Lady Mary Wortley Montague eighty years earlier, when inoculation was introduced as a preventive of small-pox and met, in the middle of the century, with the approval of the Royal College of Physicians. But Koch and Wright have, within very recent years, given considerable precision and practical direction to measures for securing immunity. For, all fallacies to the contrary notwithstanding, as the lawyers say, we have learned from them that minute and definite doses of toxins, such as are attached to the bodies of dead and sterilised bacilli, cause a reaction in the blood of an antagonistic kind, which results in the raising of its opsonic qualities with regard to the particular bacillus concerned. And the fact that definite doses of a given specific poison produces a reactive immunity—a phagocytic antagonism to the organisms that produce the poison— has a very wide application in clinical medicine and gives a clearer insight with regard to much that has already become a part of our pathological and therapeutical experience.

Thus we see more clearly why the routine sanatorium treatment of phthisical patients by exercise and rest, as regulated by the indications of the temperature chart, is sound practice. For the past three years Dr. Paterson at the Frimley branch of the Brompton Hospital has adopted more thoroughly organised and closely supervised and graduated labour exercises, at first regulated by the readings of the clinical thermometer alone, but in the past year supplemented by careful opsonic tests, which, under the direction of Dr. Inman, are found closely to correspond with the thermometric indications. Similarly beneficial results have been observed in arthritis and other bacterial lesions from the alternating conditions of anæmia and congestion locally effected by massage and the methods of Bier, and it has long been known, both to physicians and surgeons, that the opening up of serous cavities with free drainage will sometimes suffice to cure a pleurisy or a peritonitis which is demonstrably of tuberculous nature. Wright and his pupils explain these clinical observations by showing that by exercises or mechanical means, such a moderated degree of afflux of blood can be secured to a local or more or less quiescent tuberculous or other bacterial lesion, as will cause a discharge of toxin from it, and so produce a reactive upraising of the opsonic power of the blood serum and secure more effective phagocytic action. At the same time it must not be forgotten that a larger number of leucocytes are brought within the disease areas. These clinical methods of producing immunity are more nearly on all fours with the idea of vaccination—so far as the original idea is acceptable—than the artificial use alone of the sterilised toxins.

It is absolutely essential on economic grounds, as well as on those of clinical convenience, that a workable clinical index be found to guide the use of vaccines, whether given artificially or absorbed automatically under exercise conditions, in the treatment of tubercular and other bacterial diseases of any duration, before such methods of treatment can become largely available for private patients, for whom costly and expert opsonic observations are not available. Laboratory work must be brought into line with clinical observation in this, as in many other, respects, in order that its results may attain full value. An important beginning has already been made in this direction by my colleague Dr. Latham, who, in association with Dr. Spitta of St. George's, and Dr. Inman of Brompton, has contributed a valuable and suggestive paper to the Royal Society of Medicine, which treats of the relation of the opsonic indices to temperature, and discusses the value of the temperature curve as a guide in tuberculin treatment.

The clinical observations of Latham, and the opsonic examinations of Inman and Spitta, strongly support the view that, with an initial opsonic observation, and perhaps an occasional further test, the treatment of bacterial disease with vaccines can be guided with practical efficiency by temperature indications. The higher ranges of temperature are records of depressed indices, which are negative phases, induced by excessive administration or production of toxins, whilst normal or, in some degree, sub-normal temperatures correspond to a re-active elevation of the index. Just as in logarithms and other formulæ, we find in a concrete form the results of enormous mathematical labour, which can be used at sight by practical engineers, few of whom could perhaps even understand the calculations from which the results are obtained, so it is to be hoped and expected that laboratory research will yield clinical indices for the bedside guidance of the practitioner. And in proportion as the results of these minute bacteriological inquiries become available, as a part of general clinical knowledge and method, so is

the relational outlook or perspective of medical practice enlarged and deepened. Perhaps no better illustration could be found of the essential and organic connection between hospital and laboratory work, which many shallow-thinking people would wish to divorce. There is, of course, much yet to be accomplished. I do not think we are yet informed as to the opsonic indication of the greater depressions of temperature. We want, further, to know more than we did fourteen years ago about the effect of mere temperature in inhibiting or otherwise the bacillary activity by which the toxins are produced. I ventured to express the belief, founded upon clinical experience, that a high temperature inhibits bacillary activity, and so prepares for a decline of temperature, and that when the depression is sufficiently great, fresh bacillary activity is again favoured. This view does not at first sight seem to tally with recent opsonic experience, by which one would judge the resistance at least to be lowered during high, heightened during low temperatures. I am inclined to think that this discrepancy is more apparent than real, and will be cleared up by further observations. A high opsonic index is not incompatible with an activity of toxin production which may overpower it and again send up the temperature. We also want much further information as to the effect of drugs, especially of quinine, arsenic, antipyretics, alcohol, nucleins, trypsin, as well as of vital conditions, such as anæmia, menstruation, the climacteric period, etc., upon the opsonic index.

The value and limitations of the opsonic treatment of specific diseases are still under consideration, and in diagnosis I have met with several instances of errors giving rise to at least much inconvenience and expense to patients from opsonic or other bacteriological research —results being regarded too exclusively and apart from the other clinical features of the cases.

The whole question of natural or acquired immunity to specific diseases is a very interesting one. One meets with instances of persons who, after having visited health resorts for many seasons on account of pulmonary disease, have wearied of their wanderings and settled in home quarters. With perhaps a considerable amount of disorganisation of one lung, their disease at last arrives at a stage of quiescence. Such patients will now continue in this condition for years, and perhaps die from a totally different malady. I can recall two instances in which, after many years, cancer of the breast, with internal recurrence, has terminated such cases. They seem to possess a considerable strength of immunity. I have known severe attacks of influenza to fail to bring about relapse. Do these cases become immune by virtue of auto-vaccination, and are we right in regarding them as automatic and haphazard examples of quiescence brought about by conditions which are more systematically and scientifically secured by the graduated labour conditions of Paterson?—conditions, that is, effecting an auto-immunisation equivalent to larger and larger doses of tuberculin, until the opsonic index for tubercle—whatever that may mean—has become steadily high and the patient permanently protected.

It is probable that many people experience unconscious attacks of various acute specific diseases which enable them to resist attacks from subsequent exposure. It occurred to me a few years ago to see, in quick succession, three cases in which, on the strength of a positive Widal report from a Research Society, a diagnosis of enteric fever had been arrived at in the absence of any other confirmatory symptoms. In one of the cases, rooms had already been cleared and nurses secured for the enteric campaign, but the case proved only a slight one of influenza, and the patient was about his business in three days. The others were influenza and lymphadenoma respectively. Apart from illustrating the importance of regarding any one sign or symptom, however valuable in itself, in due proportion with the other features of the case, these instances were in favour of the view that the patients had been unconsciously subjected to the influence of the enteric poison in slight and merely immunising degree. They had neither of them been vaccinated against typhoid, but the gentleman to whose case I specially refer had been in South Africa during the war. Again, one comes across many cases which bear a similar interpretation, old unrecognised tuberculous depositions, febriculas, catarrhs, anomalous and slight degrees of measles, whooping-cough or sore throats so common at the commencement and the decline of epidemics, and which may be specific enough to prove protective.

One often observes the dwellers in an old insanitary house to have for years experienced no defined illness, yet a new tenant will at once succumb to an enteric or diphtheritic attack. Whether in these cases any specifically altered opsonic index obtain, or whether there is some structural change in the avenues of entry of such diseases—the tonsils, faucial glands, Peyerian glands, bronchial glands, the spleen, etc.—which renders them sterile soil for fresh invasion, I have no knowledge.

With regard to the permanence of the immunity from tuberculosis, there is a caveat to be entered. No man, in my belief, however soundly "cured," can safely return to the crowded office or insanitary factory life under which he may originally have acquired his disease. With old lesions in his lungs, however quiescent, he is liable to bacterial invasion and lodgment (other than tuberculous) about the damaged surfaces, which causes infective congestion or inflammation, and thus establishes fresh conditions for cultivation of localised tubercular bacilli, "which are not dead, but sleepeth," the toxins from which will break down his immunity.

I should like to express my sense of the indebtedness of the profession to those physicians and surgeons who have done so much to bring the research work of modern times into closer touch with clinical medicine. Many of the most important observations in medicine have been the result of patient bedside investigation. Addison's disease, pernicious anæmia, the differentiation of enteric from typhus fever, the recognition of myxœdema, and others might be quoted, and the physicians of Guy's Hospital have been conspicuous in contributions of this kind.

I have it in mind that one of the first observations leading to a symptomatic localisation of nervous lesions was derived from a case in which a dagger thrust had divided a segment of the spinal cord high up, and the effects of which were observed by a great surgeon of the time, whom I cannot at this moment identify. Our first clear views of the physiology and chemistry of the digestive process were derived from observations by Beaumont on Alexis St. Martin. It may be that, with Claude Bernard and the rise of his school of experimental physiologists, a disposition to submit problems first hand to experiment tended, for a time, rather to discourage clinical observation, and to induce physicians to accept physiological teaching for their practical guidance. If so, it was but a momentary "stand at gaze" of a practical profession in obedience to the dominance of a particular school of thought. Clinical observation had been brought into line with physiological research by Marshall Hall, the great expositor of physiological tenets as applied to medicine, who was succeeded by Charcot and Hughlings Jackson, the great clinical observers of nervous diseases, and, later still, by Victor Horsley and Ferrier, who have so successfully combined experimental and clinical methods, and, in the sense in which I am now speaking, perhaps no one has contributed more to our exact knowledge of cerebro-spinal anatomy than Sir W. Gowers, by his combined clinical and pathological observations on localised cerebral and spinal lesions, and the paths of degeneration leading from them. And at the present time the currents of nervous influence, their cerebral and spinal sources, and the territories to which they lead, are as fully charted as are the paths of human intercourse by land and sea, and the countries which they connect. Bence Jones and Garrod carried out important investigations into diseased conditions, from the chemical and metabolic side, in the patients under their clinical observation, and Dr. Pavy has, by unremitting laboratory work in connection with bedside observation, told us most that we know of glycosuric maladies, which the experiments of Claude Bernard elucidated from the more purely experimental side.

I have sufficiently illustrated my text by references to combined clinical and laboratory examination of blood conditions, to which large field a whole course of lectures might be devoted. I would pass on to allude to the encouragement given to enlightened clinical research by the Oliver Sharpey lectures at the Royal College of Physicians instituted by the generosity of Dr. Oliver of Harrogate, who has himself done so much "in searching out the secrets of nature by way of experiment," both clinically and in the laboratory. The latest and perhaps the most important development of this newer phase of practical medicine is to be found in the establishment at Cambridge of a committee for the study of special diseases, which has now been at work some two years. Composed partly of men engaged in practice and partly of those pursuing scientific research, the object of the committee is to investigate important and obscure diseases, by receiving a few cases of one sort at a time, for a period of close observation, with all the methods of modern science. This is an example which our great hospitals might well follow by the establishment of a research ward for clinical investigation of chronic maladies. It would add strength to their teaching and be of great service to the community.

It may be thought that I have diverged from my text into a disquisition about things of which I know but little. I would urge, however, on the one hand, that my argument is that all the factors of medical diagnosis and treatment, however technical and dependent upon separate inquiry and research at the hands of experts, must be brought into line and perspective with one another, and must be made comprehensible to the practising physician before they can be of real value, or at least of more than scientific interest. I have heard it often complained that the discoveries of Harvey, of Jenner, of Darwin, of Pasteur, of Lister, of Koch have each in their turn been received with incredulity and hostile criticism. Surely this is more as it should be than if they had been met with an amiable and supine acquiescence. Hostile criticism is the best advertisement, and controversy makes for education. It is right and desirable that each new phase of science, in its bearing upon the art of medicine, should be subjected to the fire of criticism, to purify it and weld it into due relation with all other factors. Until it has passed through that ideal it remains but of philosophical interest. We have learned much since the first days of inoculation for small-pox, and Jennerian vaccination, as an institution, is only defensible in perspective with the facts of the time, the positive facts of the appalling virulence and loathsome and fatal effects of the disease, and the negative fact of its actual cause not being then, nor even now, known to us. It was instituted in hygienic darkness; in the light of preventive science and with the efficacy of police sanitation, and the certainty, sooner or later, of the true nature of the disease being discovered, we may foresee the time when vaccination, employed in contact areas alone, may be adequate for the protection of the community. Had Haffkine's vaccine been known in the dark and evil days of plague epidemics in this metropolis, it might have been adopted for a disease which has since been wiped from the slate of Europe by hygienic measures alone. This does not lessen the value of Haffkine's discovery and the usefulness of its application, not in place of, but ancillary to, the more fundamentally important methods of hygiene in contact areas.

It might be arguable—I am inclined to think that it is in the minds of some—that inasmuch as, with the increased purity of our surroundings, we are becoming more and more virgin soil for specific poisons, we should be vaccinated against the principal of them, *e.g.*, enteric fever, plague, tetanus, tubercle, to which we are likely to be exposed in neighbourhoods less well guarded than our own. Except as a preventive measure in actual contact areas, it is unlikely, however, that the saving humour and common sense of the profession will ever entertain the idea of our becoming, as it were, such

pathological pin-cushions. It is probably wiser to hold immunity in reserve than to risk its exhaustion beforehand.

There never was a period when we could see so minutely into disease as we can now, and as time advances our vision will become still more penetrating; it behoves us the more to preserve the range and proportion of things lest this keener insight may but enable us

"With finer optics given, t'inspect a mite, not comprehend the heav'n."

This thesis would bear very wide illustration, far beyond my time and compass. The brilliant and penetrating searchlights, microscopic, radiographic, ophthalmic, auro-laryngo-spectro-scopic, sphygmographic, cardiographic, not to mention electrophonic, methods, and others which I have not yet in mind, with which we are now provided, must be used with much discretion and not a little forbearance. All the defects of our poor personalities, by these trenchant means disclosed, must not always be taken too seriously, and must be regarded in strict relation with age and other circumstances connected with the case. The alienist has to content himself with a standard below his own, or all his friends would be insane! In many instances, as years advance, a cardiac hypertrophy or a mitral murmur may be for a man's salvation, and should not then be regarded as a disease. A great physician to your hospital once twitted a friend, who was chagrined at having missed a pericardial friction, with the remark "that he might have treated it." It is rarely wise, except in the emergency of a critical moment, to make a frontal attack upon a high blood-pressure. Many a case of renal inadequacy, and not a few of senile decadence, have suffered from this symptomatic enthusiasm. As an American attaché said to an English general who was squandering his forces in disastrous frontal attacks, "Is there no way round, general?" I am aware that the learned Dr. Richard Meade wrote a chapter "on the disease of old age," basing his thesis upon the graphic description of that "malady" by Solomon. But is old age a disease? If so, it had best rest undiscovered with Sir W. Gull's pericarditis lest it be treated. I would rather regard the changes in organs, incidental to age, as the health of the autumn leaf preparing for the fall, and in the survey of our inward parts, as age advances, I would urge the importance of a right perspective.

"Il ne faut pas chercher midi à quatorze heures."

At the conclusion of the address Dr. Goodhart said: It now devolves upon me to ask you to carry by acclamation a very hearty vote of thanks to Sir Douglas Powell for coming here to-night to give us this interesting and thoughtful address. Of the personal attributes of Sir Douglas, whether of mind or heart, I may not speak in his presence: but in passing I recall to mind, not without some enjoyment, that I discovered, only the other day, that when I was looking up to him as already a Master in his profession, now nearly forty years ago, he could have been hardly older than I myself. There is a further reason for not dwelling upon his attributes in that he is no less a person than the President of the Royal College of Physicians. Now it is a well-accepted axiom that the King can do no wrong, which implies also that it would be inappropriate to speak within the Presence of the many kind and gracious acts that were characteristic of his Majesty. Sir Douglas is a king in his own profession—a position which can only come to very few, and one which, we may be sure, when it does come, proclaims to the world that he thus honoured is almost more than *Primus inter pares*. In that position—most responsible, most exacting—let us leave him. I prefer to-night rather to point out to you how great must have been the trouble Sir Douglas has taken in preparing this address for us. There seem to be a good many people about who think that men in his position have only to open their mouths and an address drops out. Applied to by far the greater number of political speeches, I should hold this belief to be true; but when one has to talk sense, or even common-sense, for three-quarters of an hour, the preparation needed is very great indeed. If I try to picture one thus promised to an audience during the three weeks before the address comes off, I see a man who dreams of it in his sleep; who, as he wakes in the morning, finds a gaunt hungry spectre still beside him. It goes with him to his bath—a grand opportunity to start ideas that shall regenerate mankind, but alas, also a most inopportune one, for ere he can get himself into a condition to transfer them to paper they have gone beyond recall. Then it flavours his coffee at breakfast; even the size of his egg will suggest the paucity of his ideas or the exuberance of his material—either of them an extremity exceedingly difficult to rectify. As the day goes on he learns fully to appreciate the value of two sides to his brain, for while one is writing prescriptions more illegible than usual, the other is teeming with the address. And lucky man will he be if, within twenty-four hours, some kindly chemist does not knock at his door or send an urgent message to ask if he really meant to order the poisonous dose of medicine on some prescription he has written. Well, the day proceeds, and our poor friend is seen retiring now into one corner, now another, to jot down, as they come into his head, ideas which he finds, when he comes to use them, are illegible. In his carriage he crowds his shirt-cuffs with illiterate scrawls, and generally he is noticed by his friends to be always absent and muttering to himself in a way that causes them great alarm, as it seems to associate him inevitably—well, as it is only a tribute to his distinguished position—with Dr. Savage in touching proximity. Now, I do not mean to say that Sir Douglas Powell has ever been reduced to quite such extremities as these—at least, I hope not. Nevertheless, I know that the labour of preparation has not cost him nothing, and our gratitude is due to him on that account. But one word more needs to be said which may, in addition to this vote of thanks, cause some gratification to Sir Douglas Powell in having come down here to-night, and it is this: Possibly Sir Douglas Powell does not know that the Physical Society of Guy's Hospital is one of the oldest medical societies,

I believe, in existence. Moreover, it is a very temple of fame for all Guy's men, since it includes all that Guy's holds dearest and best in its roll of honour. In coming here to-night Sir Douglas has put a brick of new life into the old edifice, which will surely enable it to live with greater vigour the many many years that we are assured it has yet to live.

Sir Douglas Powell then briefly replied.

Mr. Neville Cox moved, and Mr. Laidlaw seconded, a vote of thanks to Dr. Goodhart for taking the chair.

Dr. Goodhart, in replying, read the following letter from Sir Samuel Wilks:—

8, Prince Arthur Road,
Hampstead, N.W.
October 7th, 1908.

My Dear Goodhart,

I am sorry not to be able to be present at the meeting of the Physical Society with which I have been connected for so many years. I was always delighted to be thus associated, even by so slender a tie, with my old school. I should like now to congratulate the members, as present and past students, in the way they have improved and developed all the departments of the school since my time. At my annual visitation I never forget to remind them of the great Bacon's dictum, that *he held every man a debtor to his profession, for not only* did he get profit by it, but by way of amends he should be a help and ornament to it. Nothing, therefore, has given me greater pleasure than to see Guy's men holding distinguished appointments in all parts of the world, both from their practical knowledge in medicine and surgery as well as from their scientific attainments. I gain a knowledge of this fact not from personal acquaintance but from my constant habit of reading a journal not only devoted to the publication of some of the highest scientific work, but having a lighter vein of wit and humour. I mean, of course, the Guy's Hospital Gazette. I do not, of course, presume to fathom the depths of modern physiology, seeing the immense strides it has taken since my day, nor should I dare to know what bio-chemistry is doing, much less to know anything of the doctrine of ions. It would have been an awful sight for me in my old age to have seen anything like degradation or degeneration in my beloved hospital and school; but on the contrary I have felt nothing less than delight in witnessing the continued prosperity and renown of both, due to the wisdom and untiring energy of our beloved treasurer and to the excellent teaching of our students who have so well profited by it.

I cannot do better in taking my farewell of the students (and it may be the last), to quote the first address ever given to Guy's men then, by William Allen, about the time when I was born:—

"Your profession is a liberal one, and it is expected that your conduct shall do honour to that profession. It is not enough that you merely bring to it that knowledge which is essential to the cure of diseases. Suffering humanity requires something more, it desires sensibility of heart and those exalted feelings which distinguish the good and worthy man. These qualifications are necessary to the complete character of a medical man; they will not only be acceptable in the sight of God, but being congenial with every noble sentiment of the heart will powerfully contribute to advance even your temporal interest and enable you to make your way in the world." Now I bid them farewell, and am

My dear Goodhart,
Yours sincerely,
SAMUEL WILKS.

Mr. George Eastes then moved, and Dr. Taylor seconded, a vote of thanks to Sir Samuel Wilks for his kind messages and continued interest in the Society, and this terminated the proceedings.

Pass List.

Second Conjoint Examination, October, 1908.—G. Marshall, A. C. Schulenberg, A. C. Jap, F. G. Lloyd.

First Conjoint Examination, October, 1908.—Chemistry and Physics: F. C. Godding, A. H. Taymour. Elementary Biology: H. Mather, J. H. Pugh. Practical Pharmacy: E. A. Collins, H. Daw, D. C. Druitt, A. L. George, W. G. Pinching, A. H. V. St. John, A. Tilbury, F. J. Wheeler. Prel. Sci., L.D.S.: J. E. R. Evans, C. M. Desai.

Reviews, etc.

The price of books submitted for review should in every case be stated.

A Synopsis of Surgery. By Ernest W. Hey Groves. (Bristol: John Wright & Sons, Ltd.) 7s. 6d. net.

The author of this book, in his preface, acknowledges his indebtedness to "Rose and Carless," and, indeed, the book seems to be a very complete "contents" to this text-book, with a similar treatment of a few chapters of other books added on. In fact, it is a "cram" publication, and from the fact that yet another such book is put on the market, we suppose there must be a demand to cause the supply. This demand seems to us to be a sign of the times. Everyone wants everything without going to any trouble himself in the getting. The Socialist voter does not want to work, and he does not want to save; he only wants to be kept by the State. As students we do not want to do more practical work than we can possibly help, and we do not want to read a long text-book, or any original articles; we just want to get through our examinations! So seven-and-sixpence is spent just before "going up" for surgery, on a book in which there is all the subject in a compressed tablet form, easily taken in, easily absorbed, and as easily forgotten when the first of each of the three months is past. The matter in this book is good. It is dogmatic, which is the very essence of cramming, and so far as dogmatism allows, it is accurate. By an arrangement of indented margins and varied types, it is most easy to look up any point at the shortest notice. We can only hope that it will serve its purpose, and will enable each owner of it to "get through."

Sport.

Rugby Football.

GUY'S v. LONDON DEVONIANS.

With the above fixture the hospital Rugby programme was opened for the ensuing season, and, sad to relate, we were defeated by 16 points to 5. Owing to the absence of Jones, Archer, and Hind, homeward bound on the *Campania*, two or three others engaged with exams., and W. E. Williams and Sprague scratching late in the week, the hospital side was somewhat experimental, while the Devonians, on the other hand, were at full strength, and included in their pack McSaunders, who came up from Aldershot.

The ground was hard and sun-baked, so that the ball was extremely lively and difficult to judge, and it is a matter for congratulation that no serious mishap occurred.

Before a good muster of spectators, Guy's kicked off against the sun, and went away in promising style. Some minutes later a mark by Stringer enabled Moberley to have a shot at goal, but his effort was abortive. Even play followed till well on in the game, when a determined rush by T. S. Kelly and Trott seemed certain to score, but Lacey, dashing up, cleared brilliantly. With play transferred to the other end, Saner got Stringer going, but he was pushed into touch by the corner flag. Just before half-time Carter got off-side in his own "twenty-five," and from the resulting penalty Moberley had another shot, but he waited too long, his kick being charged down, and Veysey cleared well up the field as the whistle went for half-time.

On recommencing Lee showed some fine defensive work, but the visitors were now gaining the upper hand, and getting the ball frequently from the scrum set up an attack which ended in H. P. Kelly scoring twice in quick time. Hoby and Stranach turned the tide with a good dribble, and a little later Stringer grounded by the corner flag what appeared a certain try, but the touch judge held up his flag for touch; immediately after, however, the forwards crossed in a bunch, and Lee kicked a nice goal. The home forwards were now, alas, done with, and small wonder, for the heat was terrific and the pace almost as hot. The Devon men having played one or two matches were in better training, and, lasting better, put on two more tries through the agency of Trott and Ley. T. S. Kelly kicked two goals out of the four tries, and thus the game ended: London Devonians, 16 points (2 goals, 2 tries); Guy's, 5 points (1 goal). Team:—

Guy's.—H. Lee (back); L. B. Stringer, A. S. Roe, G. E. W. Lacey, P. J. Monaghan (three-quarters); J. G. Saner, G. B. Pritchard (halves); A. H. Crook, H. Hoby, A. Moberley, E. L. Elliott, T. D. Stout, H. Stranach, G. Roberts, H. Irvine (forwards). Referee, Mr. A. Goodall.

Remarks.—Owing to the recent commencement of the session the side was short of training, and not unnaturally the heat told heavily on the forwards, who played well two-thirds of the game, but then tired visibly. Being overweighted in the scrum they seldom got the ball, but when they do they must heel quicker and cleaner. Pritchard was slow, and should endeavour to get his "threes" going much sooner. Lee at full back was good. The three-quarter line will improve with further knowledge of each other's methods, but a new left wing must be found.

GUY'S v. CATFORD BRIDGE.

This fixture was played at Catford last Saturday, October 10th, 1908, before a crowd consisting, if one may judge from the applause, more of Guy's followers than of local partisans. The hospital had out a weaker team, on paper, than the previous week, but the change of form was most surprising, and also most encouraging, especially the forward play. Catford Bridge kicked off against the sun, and our forwards at once commenced operations by dribbling down to the Catford "twenty-five"; here, aided by high kicks, the home side were penned until, after a few minutes, Stringer, with a tricky run, grounded close in. Moberley's kick was very bad. Guy's pressed again almost immediately after the drop out, and, following on some good footwork, a bad kick by a Catford man enabled Saner to "mark." The ensuing "drop" Saner sent across, and Stranack secured almost on the line, which he threw himself over, near the post. Medlock easily goaled. At half-time the score stood 8 points to nil in Guy's favour.

Play during the second portion was more interesting, Catford doing the attacking for a time. G. Helder was prevented from scoring on three occasions by some good defensive work on the part of Stringer and Lacey; the latter at back was very sound. Soon, however, the hospital settled down and became aggressive, Medlock doing some fine things, and at last was rewarded by scoring a try after Thatcher had mulled badly. Medlock kicked the goal in good style, and, following a period of quiet play, initiated a round of passing, Pritchard and Covell handling, and Stringer eventually receiving scored a try wide out. Medlock's attempt at goal failed. A few minutes only remained for play, and towards the end Stringer, fielding very neatly in midfield, ran through his opponents, dodged Thatcher, and registered his third try. Moberley made a good attempt to add the extra points, and then, before the drop out, time was sounded, the final score being—Guy's, 2 goals, 3 tries; Catford, nil. Team:—

Guy's.—J. E. W. Lacey (back); L. B. Stringer, J. C. Covell, G. B. Pritchard, P. J. Monaghan (three-quarters); J. G. Saner, A. H. Medlock (halves); H. Hoby, A. Moberley, G. Stranach, G. Roberts, E. L. Elliott, T. D. Stout, C. G. Sprague, D. Irvine (forwards). Referee, Mr. Clifford.

Remarks.—All the forwards played well, and were "stayers" to the end; their pace, dash, and vigour augur well for a really first-rate pack. Medlock was a distinct success, and Saner played one of his best games. The three-quarters, with the exception of Stringer, were not

great. Stringer, however, was on top form, his three tries and marking of Helder constituted a good afternoon's work. Lacey at back was quite safe.

GUY'S 2nd XV. v. AFRICAN BANKS.

This match was played at Catford on October 3rd. Although we had a weak side out we managed to win comfortably by 24 points to 6. Guy's started uphill against the sun, and at half-time the score was 3—0 in favour of our opponents.

In the second half we settled down, and had things our own way. Stokes (2), Samson, Medlock, Covell, and Reynolds scored, and Stokes, Munden, and Medlock converted, the hospital winning as stated. Team :—

Guy's.—C. Pollard (back): L. Stokes, G. C. Covell, E. S. Schlesinger, B. Samson (three-quarters); L. C. W. Cane (Captain), C. H. Medlock (half-backs); V. Glendining, F. S. Adams, H. Muir-Smith. G. A. Blake, G. B. Cockrem, D. Reynolds, H. Danby, M. M. Munden (forwards).

GUY'S 2nd XV. v. CATFORD A.

At Honor Oak Park, on Saturday, October 10th. Guy's won somewhat easily by 3 goals and 1 try to 1 goal. Hunôt (2), Samson, and Clarke scored for us. The Guy's forwards played a strenuous game, but the combination of the three-quarters was poor. Team :—

Guy's. — W. P. Vicary (back); – Samson, A. D. Williams, W. T. Clarke, – Evans (three-quarters); L. C. W. Cane, F. C. Hunôt (halves); F. Lowe, V. Glendining, H. Danby, G. Marshall, F. S. Adams, G. A. Blake, G. B. Cockrem, K. E. Wood (forwards).

Association Football.

GUY'S v. CARSHALTON.—Surrey Senior Cup.

It is somewhat unfortunate that the first match of the season should have to be a Cup Tie, as a hospital team necessarily takes some time to settle down. In the above competition we were drawn against Carshalton, on their ground, and a most enjoyable game ended in their favour by the narrow margin of one goal. Our team was fairly representative, but we were handicapped by the absence of Whiteley, whom we should prefer to see playing for his own club.

The match was played on Saturday, October 10th, in ideal weather. The game was somewhat "scrappy" at first, our team taking some time to settle down, but after a short time the play improved immensely. At first, Carshalton did most of the pressing, but were kept from scoring by the vigorous efforts of our backs. Soon, however, we gradually began to get more of the game, and Birks made one or two nice runs for us, but no score resulted. At this period of the game play was chiefly confined to the left wing, King at outside right being much neglected by his halves. After about twenty-five minutes the game opened out, and King, after outpacing the opposing defence, centred nicely, but no score resulted. Our opponents now pressed strongly, and some misunderstanding arising between two of our men, their inside right pounced on the ball and scored. From the kick-off we worked the ball up to our opponents' goal, but the final shot at goal went somewhat wide. At this period of the match play became much faster, and many of us regretted our lack of training. Our forwards, stimulated by being one goal down, made vigorous efforts to attack, and from a pass from the left wing, Witts scored with a low shot. Half-time arrived with the score still one all.

On resuming, Carshalton attacked strongly, their outside right sending in some beautiful centres, but our defence proved sound, Wood making some splendid saves. Our attack was now getting much less vigorous, and, with the exception of forcing several corners, from one of which we had bad luck in not scoring, was never really dangerous. Our opponents were not to be denied, and attacked strongly, forcing several corners, and keeping our goalkeeper continually on the alert. Eventually their efforts were successful, and from a punch out by Wood their inside right secured the ball, and scored what proved to be the winning goal. After this the game was hotly contested, but towards the end the play again deteriorated. No further scoring resulted, and an enjoyable game ended slightly in favour of our opponents. Team :—

Guy's.—C. A. Wood (goal); H. R. Bastard, C. H. Mills (backs); W. W. Cook, P. S. Humm, H. V. Gibbons (half-backs); R. M. King, C. Witts, K. H. Hole, A. H. Birks, H. Glover (forwards).

Remarks.—Bastard and Mills were very sound in defence, tackling and kicking strongly, but did not seem to worry much about feeding their forwards. The halves were all triers, and did some very useful work, but we sadly missed Pedrick and Denning, who have been so valuable in former days. Humm played a useful game, but was not quite up to his usual form; we expect much from him this season. Gibbons was safe and fed his wing well. Cook, although playing in a new position, did some good things at times, especially in defence, but should remember that a half is as much an attacking as a defending force; he should prove very useful in the future. Of the forwards King was in splendid form, but did not have nearly enough work to do. Birks at inside left showed several flashes of his true form, but was greatly hampered by the grass, which was decidedly long in places. He was poorly supported by Glover, who still wastes much valuable time in centreing with his right foot, thus allowing the opponents' defence time to come back. Hole at centre was also playing in a new position, and worked hard. He is at present much more useful as a half or back than as a forward. Wood in goal brought off some magnificent saves, but some of his punches have more than an element of risk about them.

GUY'S 2nd XI. v. DULWICH WOOD.

Surrey Junior Amateur Cup Tie.

Our second team commenced the season by meeting Dulwich Wood in the first round of the above Cup last Saturday. The match was played at Honor Oak, under

splendid conditions of weather, and ended in a draw of 2 goals each. Winning the toss, Guy's started with a glaring sun at their backs, and after a quarter of an hour's give-and-take play, in which the defence on both sides showed to advantage, Eccles scored for the hospital. This seemed to wake both teams up, and corner kicks at both ends became necessary to relieve the pressure. Dulwich soon returned to the attack, however, and getting through our backs their inside right just got in his shot before being grassed by Reckitt. This brought the teams level, but before half-time Renton put us ahead again by scoring our second from a centre on the left, and Guy's crossed over leading by 2 goals to 1.

The second half of the game was less interesting, the defence again predominating on both sides. Before the end, however, Dulwich again scored by charging Rook and the ball through his own goal, after he had saved a slow bouncing shot. The game was thus drawn at 2 goals each. Team:—

Guy's.—H. C. Rook (goal); W. Johnson, K. J. T. Kerr (backs); J. A. Edmond, V. Townrow, C. E. Reckitt (half-backs): H. N. Eccles, W. Wain, H. F. Renton, — Harrison, D. A. Mitchell (forwards).

Guy's Hospital Debating Society.

The opening meeting of the season was held on October 10th, Dr. Savage in the chair. About thirty members were present. Mr. Sharp moved:—"That this House considers that the Parliamentary Suffrage should be extended to women on the same terms as it is possessed by men." Mr. O'Callaghan opposed, and Messrs. Marshall and Levinson seconded the motion and opposition respectively. A good discussion followed, in which Messrs. Reynolds, Scott, Adams, Schlesinger, Mullally, Bennett, Ryle, Stephens, Killpack, and the senior Secretary took part. Upon the chairman putting the motion to the meeting, there were eight votes for, and seventeen votes against the motion, which was therefore declared lost.

The next meeting will be on November 7th, when the subject for discussion will be "That in the opinion of this House, the modern Music Hall exerts a beneficial influence on society."

Papers by Guy's Men.

Further Observations of the Quantity and Pressure of Carbon Dioxide in Venous Blood and in Alveolar Air in Cases of Diabetes and Diabetic Coma. By A. P. Beddard, M.D., M. S. Pembrey, M.D., and E. I. Spriggs, M.D.—*The Journal of Physiology*, vol. xxxvii, part 2, 1908.

A Note on the Total Fat of Rats, Guinea-pigs and Mice. By A. E. Boycott, M.D., and G. C. C. Damant.—*Ibid.*, part 1.

From the Gazette's Special Pathologist.

W. W. M., Huddersfield.—This Fallopian tube shows marked inflammatory changes, with desquamation of epithelium and leucocytic infiltration. Groups of gram-negative diplococci have been found in the wall of the tube which are highly suspicious of gonococci. Their identity, however, cannot be absolutely proved.

PATHOLOGIST.

Periodicals received.—The Hospital, Clinical Journal, London Hospital Gazette, South African Medical Record, Prescriber, St. Bartholomew's Hospital Journal, Calcutta Medical Journal, The Broad Way.

Births.

LOWE.—On October 4th, at 31, Church Street, Southport, Lancs., the wife of Edward Cronin Lowe, M.B., B.S., of a daughter.

SCOTT-TURNER.—On October 4th, at Anerley Road, Upper Norwood, the wife of Arthur Scott-Turner, M.R.C.S., L.R.C.P. Lond., of a daughter.

SOPER.—On October 13th, at 307, Clapham Road, S.W., to Bertram and Frances Soper, a son.

Marriages.

BARTON—LEATHER.—On September 21st, at the Parish Church, Minehead, by the Rev. E. Etherington, assisted by the Rev. Twist, Thomas Henry Barton, M.B., B.S., of 43, Holgate Road, York, to Hilda, third daughter of J. H. Leather, of Minehead, Somerset, late of Cleckheaton.—"At Home," 43, Holgate Road, York, October 21st, 22nd, and 23rd.

BROOKHOUSE—PRESTIGE.—On October 10th, at Christ Church, Lee, Kent, by the Rev. Robert Pratt, M.A., Vicar of Christ Church, Deptford, assisted by the Rev. W. P. Macdonald, M.A., Vicar of the Parish, John Charles, elder son of Charles Turing Brookhouse, M.D., J.P., of Ashby House, Tweedy Road, Bromley, Kent, to Annie May, eldest daughter of John Theodore Prestige, of Mohun House, Blackheath, Kent.

GLOVER—MERRIAM.—On September 24th, at Union Chapel, Islington, by the Rev. Richard Glover, D.D. (uncle of the bridegroom), and the Rev. W. H. Harwood, James Alison Glover, M.A., M.D., D.P.H. Cantab., younger son of Dr. and Mrs. J. G. Glover, of 25, Highbury Place, to Katharine, elder daughter of Mr. and Mrs. Charles Pierce Merriam, of 79, Highbury New Park, N.

Death.

HOLMESTED.—On September 29th, at Weston-super-Mare, Major T. Holmested, Indian Medical Service, late of Hyderabad, Sind.

Eds.—L. M. & A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

October.
Sat. 31. 1st XV. v. Lennox (Home).
2nd XV. v. Lennox "A" (Away).
1st XI. v. Eversleigh (Away).
2nd XI. v. Old Westminsters "A" (Home).

November.
Mon. 2. Clinical Lecture by Mr. Eason, 1.15 p.m.
Thur. 5. Messrs. Symonds and Steward's Take-in (Messrs. Sanford and Ewing).
Sat. 7. 1st XV. v. Streatham (Home).
2nd XV. v. Streatham "A" (Away).
1st XI. v. Surrey Wanderers (Home).
2nd XI. v. London County Asylum (Away).
Debating Society's Meeting, 8 p.m.
Mon. 9. Clinical Lecture by Mr. Steward, 1.15 p.m.
Wed. 11. 1st XV. v. Oxford University (Home).
Thur. 12. Messrs. Lane and Fagge's Take-in (Messrs. Dryland and Ball).

Passim.

ON either the 29th or 31st of October—the exact date is not known—in 1795, John Keats, the most famous name associated with our hospital, and one of the most glorious in English literature, was born. In remembrance of the anniversary of his birth we are publishing, as an inset to this number of the GAZETTE, a drawing showing the young poet seated in our old lecture theatre. Mr. Wingent has represented him with an open note-book, and it is interesting in this connection to know that in an actual note-book of his, which is extant, the prosaic facts of anatomy are relieved by sketches of pansies and other flowers, and to recall an oft-quoted anecdote, showing how the poet was forming in the medical student. "The other day," on one occasion he told a friend, "during the lecture, there came a sunbeam into the room, and with it a whole troop of creatures floating in the ray; and I was off with them to Oberon and fairyland."

ALTHOUGH he had little taste for the work, Keats is said to have been diligent and careful as student and dresser. He was known among his fellows at Guy's as "Tiny Keats"—"a cheerful, crotchety rhymester, much given to scribbling doggrel verses in his friends' note-books." Those who are interested in the subject of Keats' connection with the hospital we would refer to an article called "Junkets," which appeared in the GAZETTE of October 7th, 1905. But the young man was born a poet, and it seemed destined that he should abandon medicine, for, in the words of Mr. William Watson's epigram:—

"He dwelt with the bright gods of elder time,
On earth and in their cloudy haunts above,
He loved them; and in recompense sublime,
The gods, alas! gave him their fatal love."

FOR the benefit of those who were unable to be present when Professor Raymond, of Paris, delivered a *Clinique* on nerve cases at Guy's during the summer, and also of those who, though present, were prevented by linguistic limitations from appreciating to the full the distinguished neurologist's remarks, we are publishing in our present issue an English translation of the lecture. The French version was taken down from Professor Raymond's dictation by Dr. M. Chartier, formerly *interne* of the Paris hospitals.

DR. F. W. PAVY, F.R.S., will give a course of three lectures on the "Pathology and Treatment of Diabetes Mellitus, viewed by the Light of Present-day Knowledge," at the Royal

College of Physicians, on November 17th, 19th and 24th, at 5 p.m. on each day.

General Sir Richard Harrison, G.C.B., one of the Governors of the hospital, has presented to the Wills Library a copy of his recently-published book, entitled "Recollections of a Life in the British Army." Sir Richard has seen active service in India, where he served under Outram at Lucknow; in China, and in Zululand; and during the six years previous to his retirement, in 1903, he acted on the Staff at the War Office, first as Quartermaster-General, and later as Inspector-General of Fortifications. This volume of reminiscences, compiled from journals and letters, contains many interesting accounts of places and personalities, and of British military history during the latter half of the 19th Century.

Perhaps even more interesting to us at Guy's will be the following anecdote, relating to Sir William Gull, which the book contains:—

> "Wishing to consult some good physician in regard to my general health, I determined to go and see Dr. William Gull, whose reputation was great even then, and became greater in after years. On entering his study he looked hard at me, and asked me to tell him of my birth and parentage. I thought it somewhat odd that he should catechise me in this way, but, looking upon it as a doctor's privilege, I told him all I knew. Upon which he said, very quietly, but impressively:—
>
> "'I will do all I can for you for the sake of your father, who started me in life.'
>
> "And then I heard that, when my father was rector of Beaumont, in Essex, he had come across Gull as a boy, had noticed his talent, and had sent him up to Guy's Hospital (where my great-uncle, Benjamin Harrison, was Treasurer), with a view to his starting life as a medical student. Once there, under the wing of the well-known Treasurer, the young man made rapid progress, and ended by becoming one of the most famous of the many good men turned out by Guy's Medical School, eventually having the honour of saving, under Providence, the life of the Prince of Wales, and being created a baronet."

Our First XV. provided a pleasant surprise for the majority of a good crowd of spectators at Honor Oak Park, on October 21st, by defeating Cambridge University. A thoroughly interesting and, in the end, exciting game ended in our favour by fourtries to three. It is true it was Cambridge's first match this season, but they had a strong team out, including Macleod, which is saying a good deal, and ten other Blues. We trust that the improved form which our team is beginning to show will be maintained, and we take this opportunity of reminding old Guy's men, and others who may be interested, that our home match against Oxford takes place on Wednesday, November 11th, when there is every likelihood of their seeing a good game.

The Royal College of Surgeons has at last followed the example of all enlightened and progressive examination authorities by making its diplomas M.R.C.S., F.R.C.S., and L.D.S. open to women. This decision was arrived at by the Council at its meeting on October 15th. The Fellows have been much in advance of the Members in this matter, for in the recent poll on the subject the former recorded a majority of 288 in favour of admitting women to the membership, while the latter opposed it by a majority of 703. In spite of the attitude of the members, the Council decided to act in the way we have mentioned, and since the Royal College of Physicians has already removed the sex-disability in regard to its Licentiateship, the Conjoint Diploma will in the near future be open to women on the same terms as to men, which most people will agree is as it should be.

We are asked to announce that the Twelfth Annual Dinner of the Contemporaries' Club will be held at the Trocadero Restaurant on Wednesday, November 25th (when the Chair will be taken by A. H. M. Saward, Esq., M.R.C.S., L.R.C.P.), at 7.30 p.m. A meeting will be held at 7.15 p.m. for the purpose of electing a vice-president for the year. The cost of the dinner is 10s. 6d., exclusive of wine. Gentlemen intending to be present will oblige by notifying the Hon. Secs. of their intention, and of the names of any guests whom they propose to entertain on or before Monday, November 23rd. Hon. Secs., Ernest B. Dowsett, L.D.S., M.R.C.S., 1, Gloucester Street, Portman Square, W.; Lawrie McGavin, F.R.C.S., 6, Mansfield Street, Cavendish Square, W.

All Guy's men, and especially those who were doing their Physiology a couple of years ago, will be pleased to hear that Dr. Forsyth, formerly Demonstrator in Physiology here, and now Assistant-Physician at Charing Cross Hospital, has recently obtained the degree of Doctor of Science in Physiology at the University of London. We congratulate Dr. Forsyth on this latest distinction, which will redound to the credit of his old school.

A Guy's Freshman in 1796.

When Sir John M'Mahon—sometime Private Secretary to the Prince Regent (afterwards George IV.)—died in 1812, he left as his sole executor a young medical man named William Knighton, who had accompanied Wellington to the Peninsular War, and had been rewarded by an appointment as one of the physicians to the Royal Family. As M'Mahon's executor, young Knighton came into possession of certain private papers, which it was very desirable to keep private, relating to the Prince and his unfortunate Consort. Knighton went at once to the Prince and delivered up the papers, which discreet act gained him the royal favour for the rest of his life, and he received in turn an important office in the Duchy of Cornwall and a baronetcy, and finally, in 1821, he became private secretary to King George IV., having gradually relinquished his professional duties. From this time to the death of his royal master, Knighton was a loyal and faithful servant. He exercised enormous power over the peculiar mind of George IV.; indeed, Charles Greville, in his "Diary," says that Knighton was virtually King of Great Britain and Ireland. When the Prince ascended the throne in 1820, he was heavily in debt. Knighton was therefore authorised—in the Prince's own words—"to undertake the entire management of my private affairs, with a view to the observance of the most strict and rigid economy, that we may have the opportunity of relieving ourselves from certain embarrassments which it is not necessary to mention further in detail," and by 1823 he had exercised these privileges to such good purpose that Greville records that "Knighton has managed the King's affairs admirably, and is getting him rapidly out of debt."

The most sincere and personal friendship existed between the King and his private secretary. Malicious tongues attempted at one time to bring discord between them, but in the midst of it all we find Knighton writing to his wife: "I made the King laugh heartily a few minutes since at your anxiety lest his Majesty and I had quarrelled. You do not know the newspaper tricks. That paragraph was manufactured for the purposes of mischief. All this is political. No, no; there is nothing wrong here. His Majesty and myself were never on more happy terms of feeling; it is this knowledge that produces public abuse. The King was very kind towards you, and said, 'Poor little soul! I suppose she is in a fine fuss!'"

After George IV.'s death, Knighton, who had been that monarch's good angel, gave up Court life, and occupied most of his time in travel.

* * * *

But it is with Knighton in his younger days and long before he devoted himself to the life of the Court, that we are now concerned. His father had died young, and the mother had a hard struggle to provide her son with a good education. After school-days he was apprenticed, in accordance with the custom of that time, to his uncle, a surgeon and apothecary at Tavistock. At the age of nineteen he left his uncle in order to walk the hospitals in London, and to study at the united schools of St. Thomas' and Guy's.

Soon after settling in London he writes an account of his experiences, which is an interesting example of the art of letter-writing as it was understood in the 18th Century. Mr. E. V. Lucas has called letter-writing the "gentlest art"; in the 18th Century it was also one of the most elaborate. Truly, "autre temps, autre mœurs"—

"My Dear Uncle,—Altho' this Epistle is of course to give you the details of my Journey to London, where thank God I arrived safe, yet I cannot proceed to that account without first begging you and my Dear Aunt and in fact all your good Family to accept my sincere thanks for your repeated kindneſs to me at all times, and be aſsured that no accident of Life, time, or place will ever eradicate that respect, esteem, regard, and friendship that I have for you and yours: and I also flatter myself that by acting in such a manner so as through Virtue, and respect on my Character I may be still permitted to live in your esteem and affection: for I am convinced let Vice say what it will that ("Honor est præmium virtutis") "Honour is the reward of Virtue." But you and my good Aunt in the first place most certainly deserve my immediate thanks as Parents for as such you certainly have proved to me in every respect; first in training me with paternal and unexampled kindneſs in my Youth by placing me in such a situation where I might receive a good education: and in the next place by taking me under your own protection to obtain my profeſsion and in preserving me (which I think the most valuable of all) from that vice which destroys health, prevent life and that happy one which is to come; and every virtuous and useful Study which must frame the Man, render him useful to society and himself, and lastly a bleſsed and permanent Comfort to his Parents, friends, and relatives."

This is a youth of nineteen, writing to his uncle! Afterwards follows an account of his journey to London. On the way he treats some cases:—

"... By desire of Dr. Crosman went to see Sr. Geo. Younge's Sister who was very ill, with a wound in her face. She had a violent swelling in her face to which her Apothecary had applied the curious Remedy of Sal Volatile by which means the skin was taken off and a wound produced. Applications of Cerate and Spermaceti Ung. had been applied but without healing the wound; there being a still greater discharge I ordered for her which was as follows a Blyster to be applied to her Neck; Goulard Ung. to her Face; and Pil. Coch. c Calom. to be given internally, which I understand by a gentleman in Town has just cured it.——I was likewise consulted for Miss ——, about twenty-three—from eating too much fruit a Cholera Morbus was produced an Ipecacuanha Vomit with Calomel and Dr. James's Powders after clearing the Decks cured her."

The young freshman is rather worried at the cost of his Borough lodgings:—

"I never should have conceived it to be half so expensive: everything is advanced: my dinner which was mere nothing at Bath cost me 4s. 60 guineas a Year for my Board but everything is found but washing. If you have 2 Rooms a Bed room and a Sitting room you pay 10s. 6d. per week and find yourself everything: Coals, Candles, meat & drink; so I thought it most prudent to Board. The young Gentleman who lives with me is a Mr. Penkival and is now come from Edinburgh to Difsect; he is a very good and studious young Man with him I study and afsociate. I paid £26 6s. to be admitted to the Hospital: 12 guineas to attend Dr. Cline's Lectures and Difsection. 7 guineas to attend Dr. Heighton on Midwifery. 5 guineas Mr. Cooper's Lectures on Surgery them I at present attend with care and study with delight and attention every Branch of Knowledge that gathers reason and good sense."

One can only wonder if the freshman of the present day equally appreciates his lectures! But the modern first year's student will sympathise with the opening sentiments (though he would not express himself so politely) in another of Knighton's letters:—

"The study of anatomy I find truly difficult to be attained; nor had I any idea it was so before experience taught me in this place. To obtain a thorough knowledge of anatomy requires indefatigable labour and industry; but it lays the basis for succefs in the practice and unveils the mystery of the operation, of medicine. It is a noble science in itself, a leſson to man, aud to be viewed not with a leſs degree of curiosity than wonder. The various procefses pursued by nature, the wonderful combination of parts, and that noble structure throughout, replete with symmetry and beauty, I was not a little pleased to examine at first in the dead subject. Many curious and peculiar reflections with respect to man took place, as you may imagine; and perhaps the various and complicated thoughts of men concerning the Machine and its existence were awakened at such a time ... I difsect a good deal, and shall continue to do so as the only way to get a thorough knowledge of the component parts of the human frame; and unleſs I have a thorough knowledge I shall not be content to return into Devonshire. I do not say that this is absolutely necefsary for a country surgeon; but it is what I shall aim at. As for their practice of physic, I value it very little ... The operations performed here are executed in the most masterly manner. Cline, whom I attend in Anatomy, and Cooper in Surgery, are men of the first Abilities."

He was evidently a "keen" student; and he was very careful in his choice of companions. One was a Quaker "about 40 years of age ... a man of wonderful Genius, and great abilities; *if he was not by the bye I should not afsociate with him*, for you know that is my plan. ... Another of my acquaintance is Buchan author of the 'Domestic Medicine'; these are my friends; how I ingratiated myself with them I can hardly tell, but so it is. I find no great difficulty in doing anything, nor need anyone to fear those trivial things of Life if they would apply themselves to the study of mankind."

It was his custom to correspond in rhyme with one of these "ingenious young friends." The following extract seems to deal with the Front Surgery:—

"Since me the Muses thus forsake,
An humbler beaten track I take.
Disease in every dreadful form
Bids me the healing art perform.
Oh! how I wish for deeper skill,
For Science suited to my will!
An anguished mother sends a prayer,
And makes her infant child my care;
The child, her languid mother nigh,
Calls tearful sorrow from my eye.
To enter still the cave of pain,
Though direful all, I ne'er refrain;
Where crowded sons together lie,
Frail sons and heirs to misery;
Where woes descend from race to race,
And heed not either time or place."

Such are some of the early epistolatory efforts of a man whom his royal master afterwards declared to be the "politest physician I have ever met." The sheets of moral platitudes and verbose affection which he addressed to his uncle would be little suited to the taste of this generation, but underneath the surface we can discern in this freshman of 1796 a character not so very different to that of his modern representative. There are some who are prone to imagine that all the medical students of a former day belonged to the Bob Sawyer type, but these letters of William Knighton's may remind them that there was another type, even then. And assuredly both types are in existence to-day! A. N. C.

Authorities:—*Memoirs of Sir William Knighton, Bart.*, 1838; *Journal of the Reign of King George IV.*, by Charles Greville, 1874; *Diary of Lord Ellenborough*, 1881; *Diary of Lord Colchester*, 1861; *Journal of Thomas Raikes*, 1857. The extracts are from original letters to which I have had access.

Guy's Physiological Society.

A General Meeting of the Society was held on Monday, October 19th, at 4 p.m. Dr. Pembrey was in the chair, and a paper was read by Mr. M. C. Wall on "Secondary Sexual Characteristics."

The author dealt with the evolutionary aspects of the subject as well as with the existing conditions. He pointed out that among unicellular organisms sex does not exist.

In certain metazoa the sexes are distinguished by primary characteristics only, and in the case of the majority of these the reproductive cells are liberated "passively" or at random, and fertilisation is entirely a matter of chance.

It is only comparatively high up in the evolutionary scale (when reflexes are controlled by and influenced through "the mind") that secondary sexual characteristics appear; and in animals possessing them there are distinctive differences between the sexes in mind, habit and inclination, as well as in body, the latter being, to a large extent, dependent on the former.

Considering the human race, the writer commented on the numerous psychological differences between male and female, and showed how detrimental both to herself and to the community are the practices of the "New Woman," who strives to emulate man in both bodily and mental pursuits. He then proceeded to explain these facts by Darwin's Theory of Sexual Selection.

An animated discussion ensued, in which Dr. Pembrey and twenty members took part.

The meeting was adjourned at 6 p.m.

Guy's Hospital Dental Society.

The President's Inaugural Address.

Mr. Spiller said: Gentlemen,—My first words must be to offer you my sincerest thanks for having elected me as your president during the coming year. It is an honour which I deeply appreciate, especially when I look back on the distinguished men who have already filled this office.

Our society has now been in existence for fourteen years, and I cannot let this occasion pass without grateful reference to its founder, Mr. Newland-Pedley, now Consulting Dental Surgeon to this hospital. It is largely owing to his efforts that the Guy's Dental School is in existence, and it is as some small recognition of this, and of his untiring services to the school, that the Newland-Pedley Gold Medal for Operative Dental Surgery has been founded, and I believe it will be found that this is the most valued prize which the school has to offer its students. Many of you present may be inclined to ask, "What are the uses of this society?" You may say, "We have our lectures, our demonstrations, and all our other work—why attend these meetings?" Gentlemen, I believe that you will find that this society fills a gap in your hospital life left empty by your ordinary work, for here you all meet on common ground, where outside distinctions must be forgotten. Some of you will read papers; all of you will have the opportunity of bringing forward communications, and by discussion and friendly criticism of these you will necessarily widen your knowledge and at the same time gain experience which will be of great service to you when later you become members of dental and other societies.

As a scientific society we are concerned with the progress of dentistry, and I believe it is generally admitted that few sciences or professions have made such enormous strides during recent years. Let us very briefly consider what has been accomplished.

To start at the beginning we must go back a long time, for we have evidence that some forms of prosthetic and, perhaps, of operative work were practised by the Egyptians two thousand years before the commencement of the Christian Era. Later, we find that the Greeks, the Persians, and the Romans had accurate knowledge of dental disorders, and certain ways of treating them. Later still, at the beginning of the eighteenth century, we notice that a revival

was commencing, and it was at this period that dentistry took its place as a distinct profession. France at this time was the country most distinguished for its progress in dentistry, and Fauchard was the most distinguished of her dentists. His work, "The Surgeon Dentist," was translated into several languages, and in it he proves himself a most careful observer and painstaking operator. His instruments appear strangely crude to us, perhaps, but were ingenious enough in his time, and many dental operations, including the crowning of teeth, were practised by him. In England, too, in the latter part of this century (the eighteenth) great progress was being made, and the names of Thomas Berdmore, John Hunter, and Benjamin Bell figure prominently. But perhaps Priestley's discovery of nitrous oxide gas, and Humphry Davy's experiments with it, will always remain among the most celebrated of any century in their application to dental work.

The advance made in the nineteenth century is familiar to most of you, but it is interesting to us to recall that, in the early part of it, Thomas Bell (1792–1880) was the first Dental Surgeon to Guy's.

The end of the nineteenth and the beginning of the twentieth centuries have seen discoveries which can only be described as revolutionary, but may, perhaps, be realised to some extent by considering the changes that have taken place in the practice of our dental school during the past few years. Ten years ago porcelain and cemented metal fillings were rarely used; translucent cement and cast-gold inlays are of recent introduction. Looking in other directions, our knowledge of dental therapeutics has greatly increased, as instanced by the introduction of pressure anæsthesia, and greatly improved methods of local anæsthesia for many dental operations. Orthodontia, too, has taken a firm position as a branch of dental science, and affords great scope for original work.

These are a very small proportion of the changes that might be enumerated in theoretical as well as in practical work, but are sufficient to show how great progress has been and is being made in dental science and art. And so it is of the greatest importance to you, in the profession that you have chosen, to keep pace with the times, and, indeed, it is for you, as younger members of your profession, to see that progress is well maintained in the future. Much work has been accomplished, but much remains to be done, especially in the elucidation of the problems of the causation of dental diseases and their prevention. So far our work has been chiefly curative; in the future it must be preventive as well.

It is the custom at this meeting to offer a friendly word of advice to the junior men, but I must first give a very cordial welcome to the new men present. They have chosen their school most wisely, and I can assure them that they will never have reason to regret the day when first they came to Guy's. Especially I would impress on you the necessity for thorough and considerate treatment of your patients; remember that your characters as dental practitioners are being formed now, and that as you treat your patients here so will you surely treat them when you take up private practice. Do not think any detail too small to merit your attention. Your work is made up of details, and it is only by careful attention to them that you can be successful in it. At the same time, do not at present try to specialise in your work; it is small value to you, for instance, to have done 100 Logan crowns when you have to make an all-metal one for the first time. Endeavour rather to acquire as thorough a knowledge of every branch of your work as is possible. By doing so you will certainly have the best weapon for defeating that bogie of dental practice—the unqualified practitioner.

And, lastly, remember always that you have chosen an honourable and noble profession. Strive always to maintain its highest ideals, and you will find that your labour has not been in vain.

Gentlemen, I close with the hope that every one of you will personally support this society during the coming session, and with every wish for its increasing prosperity.

Appointments.

Civil.

Anslow-Alabone, Dr. M., appointed Consulting Physician for Diseases of the Chest to the London Clerks' Association.

Hodgson, Stanley, M.D., B.S. Lond., has been appointed District Medical Officer of the Salford Union.

Isaac, B., L.R.C.P. & S. Edin., L.F.P.S. Glas., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Cerrig-y-Druidion District of the County of Denbigh.

Layton, T. B., M.B., M.S. Lond., has been appointed Clinical Assistant to Out-patients, St. Peter's Hospital for Stone, Covent Garden, W.C.

Naval and Military.

Surgeon H. B. German, R.N., has been appointed to the *Orion*.

Lieutenant C. H. Reinhold, I.M.S., is promoted to be Captain.

A Neurological Clinique.

Given at Guy's Hospital by
PROFESSOR F. RAYMOND,
Professeur de Clinique des Maladies Nerveuses, Médecin de la Salpêtrière; Membre de l'Academie de Médecine de Paris.

Gentlemen,—As I entered Guy's Hospital, the Alma Mater of so many eminent physicians, I could not but think of the names of Bright and Addison, names of everlasting fame, which will always remain associated in French literature with the diseases which they described with such remarkable genius. And, gentlemen, it is not without emotion that I stand up to address you in the very medical school where they taught, and that I take rank, for one day, amongst the teachers of the University of London, as students of which you have good reason to be proud. I desire to offer my thanks to your teachers for the great kindness they have shown me, and to you yourselves for the warm welcome which you have given me to-day.

I do not purpose in this clinical lecture—which is similar to those I am accustomed to deliver every Tuesday at the Hospital of the Salpêtrière—to undertake the description of any particular nervous disease. The careful study of the complicated symptomatology of nervous diseases should be undertaken at leisure with the help of books, in which the strict accuracy of detail and the diagrams are more likely than an easily forgotten discourse to impress on the student's mind the pathological physiology of the varied phenomena which characterise each of those diseases. But to you, whose medical school is in the hospital itself, it will be evident that a training along these lines alone would be altogether insufficient—nay, fruitless—if not dangerous.

It is a well-known saying that one should understand the patients themselves more than the illnesses with which they are afflicted; and the truth of this remark is more evident when one has to deal with those nervous diseases, a theoretical description of which only means the enumeration of very variable symptoms in an absolutely schematic order, and the various forms of which are often so distinct that one might be easily deceived into believing them to be altogether different diseases. In examining nervous patients, as you know, one should not miss the least detail: a symptom of apparently secondary importance—as, for example, the Argyll-Robertson pupil, or a certain hoarseness in the voice—is sufficient in itself to indicate either the nature of the disease or its extension to the vital centres. And clinical experience can alone provide us with the two conditions which are essential in diagnosing a nervous disease: (1) the knowledge of the true value of a symptom, so far as it indicates the localisation of the lesion, and (2) the careful and complete examination of the different systems.

Let us accordingly examine these four patients from the wards of your hospital.

As we proceed we shall discuss various unforeseen problems called up by the various diagnoses. Such a clinical study of nervous diseases is within the scope of every medical man, for they are, as a matter of fact, diseases of common occurrence, which deserve our thorough consideration because of their prognosis, and because the method of treating them has made unmistakable, though slow, progress.

Case 1.—The first of these patients is a man, aged 38, who was admitted into the hospital a few days ago for an extensive arthropathy of the medio-tarsal joint on the left side. It began three weeks ago; the foot has become gradually swollen and now shows the great deformity which you see. Its thickness in the region of the tarsus has increased almost threefold; it has also become broader, and the hollow of the plantar arch has completely disappeared. On the other hand, the ankle-joint and the meta-tarso-phalangeal articulation show absolutely no pathological change.

A few points are worth noticing in the development of this arthropathy. First of all, it is single and occurs now for the first time. Secondly, it is not associated with any heat or redness, which are the usual signs of inflammation. Lastly, its course has been altogether painless. As you see, I can handle and move this foot without causing the patient any discomfort.

And yet, gentlemen, if we question this patient, he tells us that he has had pains—and pains of a very terrible nature. They began six years ago, and since then have recurred at irregular intervals of a few weeks, in the shape of acute attacks lasting several hours. These pains, although short in duration, were sharp, and they varied in character. They took the form of stabbing pains in the muscles, quick lancinating pains in the bones and joints, sensations of constriction and smashing. Latterly these pains have become localised in the joints, always affecting the four limbs, and coming in the same form of short attacks. The patient thought they were due to rheumatism, and was,

therefore, not surprised to find one of his joints swelling gradually after one of these attacks.

But you are all aware of the difference which exists between these attacks of pain and rheumatism. The former are violent in character; their onset is sudden and their duration short; they are never accompanied by inflammatory phenomena in the joints; they are generalised all over the bones and muscles, and they do not affect the swollen articulation in particular. If in addition to the extraordinary nature of this arthropathy—that of an enormous swelling without any pain—you consider the fact that it affects one joint only, and that the medio-tarsal joint, without having touched the others, and if at the same time you note the very great range of movement at the joint—a circumstance which indicates considerable relaxation of the tendons and ligaments—and also the actual shape of the foot which has been compared by a classical simile to that of an elephant, you will recognize here the unmistakable signs of a nervous arthropathy.

And, as a matter of fact, we can observe in this patient all the symptoms of tabes dorsalis; although their power is still preserved, there is marked loss of tone in the muscles; the tendo Achillis jerk, the knee jerk, and the jerks of the upper extremities have all disappeared. There is very slight inco-ordination in the gait and in the voluntary movements, but Romberg's sign is clearly present; these apparently contradictory phenomena are easily explained by the study of the deep sensations. As you see, it is more especially at the extremities of the lower limbs that the sensory disturbances are marked; and you know that the maintenance of one's equilibrium while standing up is dependent on the joint sense in the lower limbs. Remember then, gentlemen, that the inco-ordination in people afflicted with tabes is a result of the loss of deep sensations, and you will have before you the actual basis of the treatment of locomotor ataxy by re-education. So long as the joint sense is not lost, and while there is hope of bringing it into action again, you must never despair of more or less improving the ataxic condition of the patient, and, personally, I have seen marvellous results with that treatment.

I need not lay stress, gentlemen, on the classical symptoms of tabes dorsalis; diminished sensation over certain areas; bands of hyperæsthesia; pains in the urogenital and rectal regions; paralysis of the bladder; disappearance of testicular and laryngeal sensation; inequality of the pupils, together with the sign of Argyll-Robertson; diminished visual power indicating the commencement of an optic neuritis.

Besides, gentlemen, there is no doubt in this case as to the history of syphilis which was contracted eighteen years ago; the patient has had the primary lesion and the signs of the secondary stage, and, he tells us, he remained under treatment only for a few weeks. In connection with this arises the question as to whether this arthropathy might not be syphilitic in origin. The presence of tabes in a syphilitic patient is not sufficient to do away with this hypothesis, and, personally, I have seen a tertiary arthritis, capable of being cured by mercury, in patients showing all the signs of tabes; and the question is a very important one from the therapeutical point of view. A mercurial treatment, I think I can affirm confidently, applied in this case would yield no result. The arthropathy which we see here has nothing in common with tertiary syphilitic arthritis, the characteristics of which are very much the same as those of infective rheumatism; viz., it is a multiple arthritis, shifting from joint to joint, more or less of a painful and inflammatory nature; it is not accompanied by excessive swelling, and it is altogether different from the parasyphilitic joint affections. It is also recognised by the bony changes, which very often occur coincidently.

I remember a case of a syphilitic arthritis occurring in an ataxic patient, where an irregular thickening of both tibiæ was noticeable; one of these bones had actually become double its original size. Nothing of the sort occurs in tabes. On the contrary, the bone shows a diminution of its calcareous elements, with a corresponding higher proportion of the organic elements, viz., the osteoblasts, and consequently the bone becomes lighter: the medullary canal becomes larger, the total thickness less, and that, as you know, is the cause of spontaneous fractures.

In addition, the epiphyses shrink, and their tubercles get obliterated, and this process of rarefaction at the epiphyses is one of the causes of the abnormal mobility of the joint. The actual reason for this trophic change in the skeletal parts is, however, not well known. In this purely clinical demonstration it is sufficient for me to remind you that it has been suggested that the changes in the spinal cord are accompanied by changes in the ganglia and in the peripheral nerves. But are the trophic centres really the seat of any lesion? This fact has not been clearly demonstrated yet. Perhaps one must consider that the loss of sensory power plays the great part in the pathology of these bony changes. This loss of sensation, moreover, seems, from another point of view, to be

one of the essential conditions for the production of these arthropathies. Traumatisms occur constantly on these insensible joints without the patient knowing anything about it; he has lost the ordinary means of protecting himself against them, *i.e.*, the reflex contraction of his muscles. Add to that the diminution in muscular tone, the relaxation of the ligaments, and the rarefaction of the epiphyses, all of which allow of an abnormal mobility of the joint, and you will understand how much the joint is exposed to the ordinary complications which follow on traumatisms—serous and hæmorrhagic effusions into the joints and the separation of the cartilage from the bone. The trophic changes which have previously occurred in the articular and peri-articular tissues account for the great swelling and the abnormal mobility of the joint, which is increased still further by the stretching of the capsule and of the ligaments.

However, in addition to these phenomena of dystrophy and rarefaction, one can often notice —especially in the foot, which is the part most exposed to repeated traumatisms—certain inflammatory lesions, hyperplasia of the periosteum and of the soft parts of the joint. In such cases movements at the joint are limited, the bony extremities appear to have increased in volume, and, if the arthropathy is situated in the foot, the latter shows considerable swelling and deformity, as you see here. Loss of the deep sensations, trophic changes in the bony epiphyses and in the soft parts round the joint, preparing the way for the appearance and development of arthropathies on the slightest provocation—such is the general linking together of these phenomena.

Trophic disturbances are not very amenable to treatment, and as a matter of fact, for arthropathies of this nature one can only suggest palliative treatment. What one should do particularly is to try to prevent their occurring. The patient suffering from tabes should be warned of the dangerous complications which may follow on the most trivial accidents; he should be advised to change his work as far as possible, and to wear boots with firm, resisting soles. Furthermore, one should try to make up for the diminution in the amount of phosphates either by giving him phosphoric acid, as it used to be done formerly, or better still by administering lecithin.

One last word gentlemen, with respect to the attacks of pain, from which this patient has suffered for the last six years—what can we do for him in that direction? Would treatment by mercury be of any use? In my opinion, in the case of a patient of this sort, not very advanced in age, not suffering from any visceral trouble, one should try a series of injections. Such a method, practised carefully, is devoid of danger, and sometimes yields good results. On the other hand, during the last few years I have been practising a series of injections of sodium nitrite, starting with 0·04 gramme and increasing the dose to 0·08 gramme. It seems, in fact, as if these tabetic crises were connected with an intense constriction of the vessels supplying the ganglia, on the posterior nerve-roots, and the beneficial influence of the nitrites in dilating the vessels has been confirmed by practice. Add to this general treatment the various forms of electrical treatment, the re-education of the joint sense where it is not completely abolished, and you can do a great deal of good to the patient; we might have been able to do more for him, if the patient had been conscious of the gravity of his disease and had come to us before the appearance of the arthropathy.

Case 2.—Gentlemen, I want you to watch carefully this patient as she comes in, and to observe her manner of walking and of sitting down. I need not lay stress on the fact that one should always keep before one's mind the first impression one has had of a patient. Very often it indicates the diagnosis, for we know how very inaccurate the patients' answers may be to the simplest questions, and how they frequently direct our attention to insignificant details, having no idea of a certain amount of hesitation in their walk, of a tremor or of an attitude, which are nevertheless characteristic.

Now you have noticed the difficulty this patient has in walking; she advances slowly, taking short steps; her limbs seem stiff and heavy, so much so that the foot drags on the ground at each step. Next you notice the way in which she sits down; she clings firmly with both hands to the nurse who accompanies her, and remains quite stiff, holding her body straight, obviously contracted to oppose any flexion of the spine, and showing by her attitude that the movement causes her a certain amount of pain. Well, gentlemen, these rapid observations have brought out the two important points in her clinical history, which we are about to consider: (1) Spastic paraplegia, (2) Spinal symptoms. The patient is twenty-six years of age; married, with two children who are delicate in health, but have never suffered from any very serious complaint. The husband has always been in excellent health. There are no morbid affections in the family history, no hereditary diseases. Although she was never strong, she

never had any disease of importance until the age of twenty-three. Three years ago, during her last pregnancy, she felt some rather indefinite pains in the back, more particularly in the lower dorsal region, and these assumed the character of girdle pains. She put them down to her pregnant condition and thought no more of them. Shortly after she experienced sensations of formication and numbness in the left hand, and soon the same symptoms appeared in the lower limb of the same side. The right arm then became affected in the same manner; the two lower limbs gradually became heavy and slightly spastic, thus causing a difficulty in walking.

After the birth of her child, the patient found that the abnormal sensations in the upper limbs had almost completely disappeared, but that the lower limbs remained in their state of relative weakness. For two years these symptoms retained very much the same character, even with an occasional change for the better, but during the last few months they have gradually been getting worse. We have before us now a condition of spastic paraplegia with a marked diminution of muscular power equally distributed over the different segments. Bear this fact in mind, however—there is no atrophy in any of the groups of muscles. The knee jerk and the Achillis jerk are exaggerated in both limbs; on both sides one can obtain a clonus which soon ceases, however, and the plantar reflex is extensor.

In addition, during the last few months, retention of urine and fæces, followed by incontinence, has occurred, indicating paralysis of the muscular coats of the viscera and of the sphincters at the same time. Lastly, we have looked for the presence of referred pain, but we have only found a band of hyperæsthesia over an area corresponding to the two last dorsal nerve roots. Let us note that the lower abdominal and anal reflexes are diminished, but have not completely disappeared.

We are thus dealing with a case of spastic paraplegia, associated with visceral disturbances, which is obviously organic in nature, and which is clearly connected with a lesion of the cord in the dorso-lumbar region. We have now to find out the cause of this condition.

We should always think of syphilis before anything else in matters relating to the nervous system. A careful examination of the patient does not reveal the presence of this disease, which, if it did exist, would probably be recent and would not fail to show itself somehow. We are also told that she has had two children, both of whom are now in good health, and that she has had no miscarriages. In case we had any doubts, however, we should not hesitate to try an experimental treatment.

When considering progressive spastic paraplegia, particularly when it occurs in a young woman and is not accompanied by corresponding sensory disturbances, one should think of disseminated sclerosis as the next probable cause. At one time many people were of opinion that paralysis of the sphincters was an exceptional occurrence in that disease. As a matter of fact this condition is present much more often than was believed then, and I should like to mention to you the case of a patient in whom the paraplegia was preceded for a few months by incontinence of urine and fæces, although it is true that this incontinence did not last long. We must not therefore look upon this symptom as an argument against disseminated sclerosis. Again we find in this patient a nystagmus which is limited to the horizontal movements of the eyeball. This is, as you know, one of the most frequent signs of disseminated sclerosis. Are we therefore to look upon it as a characteristic sign of this disease? No; the nystagmus which we are speaking of is much too common in healthy individuals to allow us to take it into consideration whilst forming an opinion. It becomes a very valuable sign only when it is associated with the other symptoms of disseminated sclerosis; and we cannot find in this patient any signs of intention tremor, incoordination, difficulty in the speech, vertigo, or sensory phenomena, all of which are characteristic of this disease.

On the other hand, gentlemen, I beg to draw your attention again to the spinal symptoms:—violent pains originating spontaneously and lasting for some time, increasing in intensity when pressure is applied at the level of the last two dorsal veretebræ, the spinous processes of which are slightly prominent: contraction of the muscles of the back, preventing any movement of the vertebral column; finally, sharp stabbing pains, intermittent and transitory in character, worrying the patient when she coughs, and distributed along the course of the eleventh and twelfth dorsal nerves, whose points of exit are likewise tender to pressure, a phenomenon which clearly indicates a pathological process involving the sensory roots.

The bilateral character of the lesion and the great pain in the region of the spinal column itself would not fit in with the hypothesis of an

innocent tumour, fibroma or psammoma, developed from the meninges. There is, of course, no reason to think of a malignant growth. If, on the other hand, we take into consideration the presence of early phthisis at the left apex, the conclusion which forces itself upon us is that we are dealing with a tuberculous pachymeningitis, involving more especially the sensory roots and surrounding the cord with an envelope of new growth. It is very likely that, at the present moment, this localised meningitis has not confined itself to compressing the cord. The pathological process has probably extended through the lymphatics to the peripheral parts of the cord, a certain area of which has become infiltrated. Besides it is very difficult to say how great is the extension of the process, because when it takes place gradually, it sometimes happens that a great part of the cord is destroyed without there being complete paraplegia.

However, in this patient the relative persistence of control over voluntary movements and the absence of anæsthesia of segmental distribution seem to indicate that, both in the roots and in the cord, the process is still in the stage of compression and not infiltration. As to the actual seat of the lesion in the cord, there are several signs which will enable us to make an accurate diagnosis. The fact that the paraplegia does not extend upwards beyond a certain point, and that the jerks (patellar and tendo-Achillis) are exaggerated, associated with a tender spot in the vertebral column, and with propagation of pain along the course of the last two dorsal and the first two lumbar nerves, suggests to us that the lesion is situated at the level of these nerve-roots, over an area corresponding almost to the last three dorsal vertebræ.

The sensory disturbances which had occurred previously in the upper limbs are undoubtedly connected with a similar lesion situated at the level of the brachial plexus—a lesion which is only slight, and which is probably half cured at the present moment.

There is one more point, which is important, both theoretically and practically, and that is, to know whether the meningitis is connected with any tuberculous caries of the spine. It is very difficult to say *a priori*, for you are well aware that, in adults particularly, it is not uncommon to find a localised tuberculous meningitis without any disease of the bone being present. A long time ago I called attention to the presence of patches of inflammation of a tuberculous nature in the coverings of the brain. Similar lesions occur very frequently in the coverings of the cord; this condition is known as Pott's disease without caries of the bone, and I have had the opportunity of examining a good number of these cases during the last few years.

The absence of any deformity is far from being sufficient in itself to eliminate caries of the bone, because there are many examples of Pott's disease without kyphosis. In this particular case the deformity exists, and accordingly all doubts are removed. Had it not been present, the great tenderness of the spine and the marked contraction of the muscles would have been sufficient signs on which to diagnose a bony lesion.

I said just now that this question was of practical importance. And so it is, because disease of the bone requires to be treated by complete immobility, and this is best obtained by applying a jacket of plaster of Paris; whereas pachymeningitis gets well with continued rest, absolute immobility of the spine not being necessary. Leaving out the operative treatment, which should be thought of only for certain cases, I recommend absolute immobilisation of the spine, as far as local treatment is concerned, and I am convinced that the lesion of the cord is as yet so little advanced as to allow to a great extent of the return of function in the lower limbs and in the sphincters should the focus of infection be extinguished. The interruption in the development of the upper focus is the best proof of the possibility of such a cure.

Case 3.—Gentlemen, it sometimes happens by good fortune that hospital practice presents opportunely to the observation of the physician cases which are of comparatively rare occurrence. This patient, third on the list, is afflicted with an arthropathy connected again with a nervous disease, the most important symptoms of which are the multiple trophic disturbances which it shows.

We have here before us a man, aged 47. His work consists in laying metals on a railway line, and I must tell you at once that neither in his family nor in his own history can any morbid antecedents be detected. He has never contracted syphilis; he is a teetotaler; he is married and has nine healthy children.

Six months ago, while clipping a hedge, he felt a pain in his shoulder, and his impression was that something had given way. He went on with his work all that day, but this slight traumatism—if we can call by that name an effort made whilst he was engaged in very light work,—was followed, as we shall see, by

very serious complications. A short time afterwards the condition of the shoulder became worse; the pain increased; coarse creakings could be felt and heard at the slightest movement, and the gradual contraction of the muscles round the articulation soon brought about complete fixation of the joint. It was first thought to be a dislocation, and accordingly attempts were made to reduce it. This fresh traumatism produced a worse condition of affairs, and gave rise to renewed pain and the considerable swelling which you observe now. The whole process took place without any febrile symptom or any phenomenon that might be considered rheumatic in character.

As you see, the right shoulder is globular in shape; by palpation one can perceive a deep fluctuation, unmistakably inside the joint and altogether unconnected with the serous bursa situated under the deltoid muscle. By moving the limbs in various directions, loud creakings can be heard. Ever since the patient has kept his arm at rest the pain has almost entirely disappeared, and the muscles have ceased to contract. The muscles of the shoulder as a matter of fact show considerable atrophy. There is no limitation of movement, but by applying pressure to the head of the humerus it can be displaced laterally, a fact which indicates undoubtedly a great distension of the capsule. Besides, it is impossible to gauge accurately the size of this extremity of the bone, on account of the swelling over the region. Finally, it is very probable that the effusion into the joint is not the sole cause of the swelling, but that the hyperplasia of the capsule, the synovial membrane and the tissues round the joint share in its production.

Here again, then, we have a big arthropathy which has developed without any rise of temperature, which is not painful provided the limb is kept at rest, which involves one joint only, and the cause of which was a very slight traumatism. These are obviously the characters of an arthropathy due to trophic changes, an arthropathy of nervous origin.

Whilst we have been considering these facts, gentlemen, your attention has no doubt been attracted by the abnormal appearance presented by the arm of the same side; you have not hesitated to associate the two conditions, and I propose now to tell you the clinical history of this deformity.

Eighteen years ago, while he was fixing some metals, the poor fellow's right arm got crushed. The result was a large, deep and lacerated wound, extending from the internal border of the thumb to the palm of the hand. According to what he says, there was no fracture of the metacarpal bones, but the wound took more than five weeks to heal. However, neither then nor later on did he experience the sharp pains or any of the phenomena of ascending neuritis which are frequently the consequence of such traumatisms. Shortly after the accident, the interossei muscles and the muscles of the hypothenar and thenar eminences began gradually to atrophy. Little by little, the first two phalanges of the whole hand became fixed in the position of extension, whereas the third remained flexed, giving to the hand the characteristic appearance of "la main en griffe." The process of atrophy then extended up the forearm and the arm. The muscles of the shoulder were already wasted before the development of the arthropathy, but the condition of the joint seems greatly to have increased the atrophy of these muscles.

I shall not describe to you in detail this condition of muscular atrophy; it is, however, a condition which should be carefully studied and observed from the point of view of electrical treatment. It is sufficient for me, in this short clinical examination, to tell you that it involves all the muscles of the right upper extremity, particularly those of the hand and the forearm, which, as I have told you, were the first affected.

The tendon jerks of the forearm are diminished in intensity; the olecranon jerk is normal. Lastly, on the left side, one can see that the deltoid and the group of flexors of the forearm are beginning to atrophy, and that the tendon jerks are somewhat exaggerated. The slow but gradual progress of the muscular atrophy, its segmental distribution, its extension to the limb of the opposite side, and the well-marked fibrillary twitchings, associate it clearly with a pathological condition of the cord. Certain peculiar sensory disturbances, and certain trophic manifestations, apart from the arthropathy itself, enable us to form an accurate opinion as to the nature of the lesion.

All over the right upper limb, and particularly along its internal border, one can observe, without having any doubt about it, the phenomenon of dissociated anæsthesia, viz., loss of the senses of pain and temperature without loss of the sense of touch. It occurs also, but is not nearly so well-marked, on both shoulders. Again, contrasting them with the flatness of the hand, you can observe these round swollen fingers—sausage-shaped, to use a current expression. The nails are friable and show striations; the whole extremity of the limb has

a bluish tint, associated with much sweating, in spite of the loss of the heat sense. Let us add to all this the presence of a kyphoscoliosis in the cervico-dorsal region, and we have, gentlemen, the signs of syringomyelia so well-marked that I need not insist on the diagnosis of that disease.

To come back to the point from which we started, the case before us is one of a trophic arthropathy of syringomyelia. Although it is closely related to the arthropathy of tabes dorsalis, it differs from the latter in several respects, particularly as regards the bony changes. We cannot afford to enter into a discussion of its pathology now; let it be sufficient to note that, contrary to what happens in tabes, it involves usually the joints of the upper extremity. Now there is, gentlemen, another question of the highest importance, viz., the exact localisation of the lesion and the extent to which it has spread, since this has a great bearing on the prognosis. Here, as in the majority of cases of syringomyelia, we have a lesion which was at first localised in the lower cervical region. The formation of a glioma began in the anterior cornu, then gradually spread to the posterior cornu of the same side, and finally attacked some of the anterior and posterior horns of the opposite side. It has obviously not yet invaded the pyramidal or sensory tracts, since no motor or sensory disturbances, no interference with the reflexes even, can be made out in the trunk or in the lower limbs.

But we must note, on the other hand, that the pathological process, starting as it did in the cervical enlargement, has been gradually invading the upper segments of the cord. Little by little more of the motor cornu, corresponding to the upper roots of the brachial plexus, have become involved; and already it is spreading higher still, as is shown by two symptoms I am going to tell you of, the importance of which you will appreciate. On the right side the pupil is in a state of myosis, the eyeball is slightly depressed, and the palpebral fissure is narrowed. These signs, as you know, indicate paralysis of the sympathetic supply to the eye, and, in this particular case, they support the hypothesis of a lesion of the sympathetic centre which is situated in the fourth cervical segment of the cord. In addition, by touching the tongue (and I wish to lay stress on this method of examination), we can observe a marked atrophy on the right side, associated with fibrillary twitchings; this is the sign that the nucleus of the twelfth nerve is involved in the lesion, and consequently there is now no doubt as to the progress of the latter towards the bulbar centres.

Now everybody knows that the implication of the medulla is a grave stage in this disease. Are we to conclude from this that we must here expect a fatal termination shortly? I do not think so; the development of the disease up to now has been very slow, and it is not unlikely that it will retain this character, and besides it usually happens that the nuclei of the twelfth and of the fifth cranial nerves are involved long before the disease reaches the vital centres of the medulla, and there are cases on record where, in spite of considerable atrophy of the tongue and paralysis of the masticatory and laryngeal muscles, the disease remained stationary for several years.

Furthermore, gentlemen, the time when the physician was quite powerless to check the fatal progress of the disease has gone by. The modern method of treatment, which I can speak of with experience, having applied it personally, has been most successful in the hands of those who have tried it, the more so in that it not only checks the progress of the disease, but also causes retrogression and even cure of many of its symptoms. The treatment, which consists in the application of the X-rays to the seat of the lesion, has already been discussed in several articles, and the rules to be followed in applying it have all been laid down. The Sabouraud pastille, which we use in France, enables us to estimate with sufficient accuracy the quantity of rays absorbed, measured in Holzknecht units, and the Béclère radiochromometer helps us to measure the degree of penetration of the rays, which, in this particular case, should be 7 to 9B according to our units. To those of you who wish to investigate this matter more thoroughly. I should like to recommend a paper which was read before the Neurological Society in December, 1907, by MM. Beaujour and l'Hermitte; you will find in it an account of the case of an American doctor who had been suffering from this disease for the last two years, in whom the sensory disturbances have now disappeared altogether, whilst a marked improvement has taken place in the motor symptoms. We cannot say yet what is going to become of these patients in the future, but without any doubt we have in this treatment a powerful weapon which it is the duty of every physician to make use of.

Case 4.—Gentlemen, there is one more patient whom I want to introduce to you, and her examination will not take long, since the only symptom she has is the objective phenomenon

which you will not fail to observe directly she comes in.

She is 40 years old, single, and she has never had any serious disease up to now, only a few attacks of indigestion now and then accompanied by headaches. About eighteen months ago she suffered from a rather severe attack of influenza, and for several weeks afterwards she was in a state of general weakness. About that time she began to experience some lancinating pains in the right arm, sensations of formication and "pins and needles" in the hand, more especially in the tips of the fingers. After that the limb became heavy and got tired more easily; the fingers, particularly the middle one, actually showed some signs of paralysis. She also remembers that her sense of touch was somewhat impaired, and that she had only a very imperfect idea of objects which she held in her hand. Finally, when she attempted to work, her hand, she says, started trembling, only slightly at first, the range of the vibration not being great; she was on that account debarred from sewing with a needle, but she could still perform light work. At the end of two or three weeks, the sensory symptoms ceased altogether, and shortly afterwards power returned in the whole limb, but the phenomenon which at first had been of quite secondary importance—I mean the tremor—increased gradually until it got to the state of marked intensity which you can see now, and since then it has persisted without any improvement whatever.

The retrospective diagnosis of these various stages must be made; without doubt she suffered from a slight neuritis following closely on the influenza, and giving rise to the weakness and the uncertainty in the voluntary movements, but the tremor stands out clearly as an independent phenomenon, and for that reason we must consider it carefully. This tremor, gentlemen, is not constant, and it is by thoroughly investigating the conditions which cause it to disappear or to become exaggerated that we shall find the features about it that will suggest a diagnosis.

First and foremost, like every tremor, it ceases during sleep. More than that, it does not go on without interruption while the patient is awake; at times it actually remains absent for several hours. It appears particularly when voluntary movements are performed, and more especially when the movements require great attention and exercise of will power. In automatic movements—as, for instance, when the patient eats—it is reduced to its minimum, and she has not much difficulty in attending to her daily wants. Further, it ceases when she holds her arm with her other hand, and you can see how slight is the effort required to stop this tremor in its greatest degree of intensity. When the arm hangs down by the side of the body, it usually does not tremble. If, however, the tremor comes on—and it comes on the more easily when the patient feels herself observed—it is only necessary for her to lean against something, or catch hold of something, for the vibrations to cease. Let us add that she has no control whatever over this involuntary movement, either when it appears or when it stops.

Its occurrence during the performance of voluntary movements seems to class it amongst the intention tremors. But in reality it is different from the latter. In the first place it may occur independently of any voluntary act; secondly, you will observe that it is *not* only during the movements that it occurs, but even before the execution of the movement; lastly, it varies in intensity according as the act is more or less difficult to perform.

The tremor affects the whole of the right upper limb; the vibrations can be observed taking place simultaneously in the forearm and hand in the direction of extension and flexion alternately, and in the arm in a direction which varies according to the position of the limb. There is the additional fact that it is strictly limited to the right upper limb. The rate of vibration is rather slow; it is approximately four a second; the amplitude is variable, and the intensity is influenced by many conditions, and particularly by the emotions of the patient. It follows from this that the tremor varies from day to day.

Such is, gentlemen, the simple analysis of the essential features of this tremor. You must have noticed certain peculiarities,—some contradicting others—which have forced themselves upon our attention during this discussion, but the most thorough understanding of the features of a tremor would not be enough to enable us to make a definite diagnosis, and we must fall back upon the general examination of the patient. Now this examination has already been carefully made, and nothing else can be detected. She shows absolutely no organic symptom as far as the nervous system is concerned; no neurosis whatever; no sign of general ill-health; no trace of any intoxication. The only sign that we can make a note of is a certain amount of contracture in the upper right limb, not accompanied by any anæsthesia—contracture which varies in intensity, and at times even completely disappears.

The only fact, then, we have to work upon is this tremor, absolutely localised to the right upper limb, and constituting the sum total of the

patient's symptoms. The number of possible hypotheses is accordingly very limited, but this, as we shall see, is far from doing away with the difficulty of the problem.

First of all, because the symptom has been present for the last eighteen months, without being associated with some organic nervous phenomenon, it is evident that we must eliminate pathological conditions of the cord or of the cerebrum (disseminated sclerosis, cortical irritation, &c.) which might have given rise to a tremor of this nature. On the other hand, I have already mentioned the fact that there is no ground for suspecting any intoxication. We are then left with the tremors which arise from neuroses. There is a disease which, in the present state of nosology, one classes amongst the neuroses, because one cannot do any better,—I am referring to Parkinson's disease. Now you all know that this disease begins very often with a localised tremor—hemiplegic or even monoplegic in character, but you know also that the form of vibration sometimes departs from the usual type with which you are so familiar. That is why in this patient, although this tremor seems quite unlike anything in the classical description of Parkinson's disease, I would have hesitated to give up the idea, were it not that the disease cannot be confined to one arm for such a long time.

Is it then, a tremor belonging to the class of those known as "essential?" You are undoubtedly familiar with this form of tremor, which is transmitted from ancestors, which may affect several members of the same family, and which is an indication of degeneracy of the nervous system. It can come on at any age, according to the transmitted qualities, from childhood up to old age, when it is distinguished as senile tremor. Now although in this patient we find on the maternal side a tremor of the generalised type, which besides appeared late in life, I do not think we can look upon the present case as belonging to that class. The presence of contracture, the too absolute localisation of the trouble, the marked influence exercised over it by the patient's emotions, allow of its being classed among the neuropathic tremors. However, you should not forget to keep in mind this hereditary tendency to tremors; perhaps it plays a part in the pathogeny of the present condition.

Can we go further, gentlemen, and assign a more definite nature to the phenomenon we observe here? Are we dealing with a psychical trouble, a motor phenomenon associated with a fixed idea? In order to give a satisfactory answer, we must have an exact knowledge of the patient's mental condition. Those who are treating her can state positively that it is not so.

Is it, then, of hysterical origin, an automatic act due to disturbances of the function of the cortex? The presence of the contracture, indeed, is a great argument in favour of this theory. On the other hand, the absence of all anæsthesia, and the negative result obtained in looking for the signs which are characteristic of that neurosis, prevent us from making a definite diagnosis of hysteria. There is, besides, a mode of experimentation which is employed with a view to finding out the truth of the matter, viz., suggestion either in the hypnotised state or when the patient is awake; that has been tried and has yielded negative results.

To conclude, I may say that I would place this tremor in the domain of subconscious acts, and on that account it belongs to the group of hysterical manifestations, and, in my opinion, it should be treated by the method which I practise in these cases; on the one hand, complete rest, isolation, improvement of general condition of body and mind alike; on the other hand, re-education of the voluntary acts by mechanical means.

As you see, gentlemen, in this brief study of a few cases chosen at hazard from amongst the patients of this hospital, I have only considered the clinical and therapeutical aspects of their diseases. The close attention with which you have listened to me is the best proof of the depth of your interest in those questions of practical neurology which every medical man, when examining a patient at the bedside, should keep before his mind.

Change of Address.

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(The Editor will be very glad to receive a postcard with notes of any change of address.)

The Officers' Training Corps.

It is without doubt the duty of every citizen to train himself to take part in the defence of his State, whether by bearing arms or by abetting those who do so, and whether the medical student intends to make the Medical Service of the Forces his career or not, the possibility of his being called upon to take an active part in the service of his country in the field should be borne in mind by him. For on the outbreak of war on a large scale a very considerable body (about 1,000) of medical men will be required to complete the medical establishment of the mobilized Army, in addition to the Army Medical Officers already serving, and a continuous supply to fill vacancies caused by wastage and in case of extended operations will be necessary. And those who have received training are infinitely more valuable to the Service than those to whom everything connected with military life is unknown. It is for the officer grades throughout the Army that a potential reserve is required.

To assist in meeting this demand an organization called the Officers' Training Corps has been devised, which will give to students at public schools and universities a systematised military training, to prepare them to take their places as officers in the Special Reserve and the Territorial Force. All arms and branches of the Army are represented in this educational scheme—Cavalry, Artillery, Engineers, Infantry, and Army Medical Service, and the training is carried out by the schools and universities under War Office supervision and financial assistance.

For purposes of its special training each branch is formed into a special "Unit," such as a Troop, Battery, or Company—in the case of a medical unit a section of a Field Ambulance, and to obtain recognition as a unit thirty cadets must come forward. Such a medical unit already exists at Edinburgh University, others are in process of formation at Oxford and at Cambridge Universities, and it is hoped that one or more units may be obtained from the Medical Schools in London.

Service in the Officers' Training Corps involves no obligation to join the Special Reserve or the Territorial Force, and it makes no heavy demands upon the cadet in point of expense, his uniform, and messing while in camp being paid for him, as well as the cost of his journey to and from the camp.

The demands upon his time are not unreasonable. He must, to earn the grants, and to make himself an "efficient," attend thirty instructional parades in the first year, fifteen in the second, and eight days in camp, besides the general inspection.

The necessary training lasts for two years, and he should obtain by examination Certificates A, at the end of the first, and B at the end of the second year. The possession of these certificates gives him certain advantages, and earns for his unit certain sums of money. The training is carried out by instructional parades, demonstrations, lectures, and practical work in camp, with other troops, the parades and lectures being taken mostly in the winter, and the camp being held in the summer.

The subjects of training are :—

Squad and Company and Ambulance drill.
The work of Field Medical units.
Sanitation in Barracks, Camp, and on Line of March.
Military Law and King's Regulations.
War Establishments, and the organization, discipline and administration of a company in peace and war.
Military map reading.
Royal Army Medical Corps training.

On the formation and formal recognition of a unit by the War Office, equipment and the services of a non-commissioned officer instructor can be obtained, and work can commence, and it is desirable that this should be achieved before Christmas so that training may be well advanced by the time of the summer camp.

Copies of regulations may be obtained from the Dean of the School.

Experiences of another Medical Motorist.

Some of the readers of the Gazette may be interested in a few further particulars as to the probable cost of a motor in a medical man's practice. Two letters on the subject have recently appeared in these columns which show an apparently big discrepancy. I will endeavour to explain this by quoting a few figures. As regards Dr. Anderson's experience, I fancy he will hardly continue to get off so cheaply in the way of expense. The cost of the first year's motoring (or, better, the cost of the first 10,000 miles or so) is no guide whatever to the cost of subsequent years (or of the subsequent 10,000 miles); further, he makes no allowance for depreciation, which is a most important factor. A motor once used is "second-hand"; a horse used for twelve months is frequently enhanced in value.

I quote, first, some figures put forward *by a motor firm* said to be those of a country practitioner who drives his own car, a 10–12 h.p. four-cylinder. They are for twelve months :—

Petrol (400 gallons)	£22	0	0
Repairs	5	5	0
Tyres	20	0	0
Boy	39	0	0
Insurance	7	0	0
Sundries (Oil, Grease, Accumulators, Licences)	9	12	0
Total	£102	17	0

No details of mileage are given, but allowing fifteen miles to the gallon, which will not be far wrong for four cylinders, makes the cost per mile slightly over 4d., which allows nothing for depreciation, interest, etc.

Next, I give the figures of the running expenses per annum for a 10–12 h.p. two-cylinder Darracq, which are

taken on an average of two years' running; the car is managed by a clever business friend of mine who thoroughly understands the subject:—

Petrol (530 gallons)	£25	9	7
Repairs	62	16	7
Tyres	40	7	2
Chauffeur and Livery	64	4	3
Insurance	8	17	0
Sundries	18	2	0
Total	£219	16	7

Miles run, 10,600 per annum, which gives us a cost of approximately 5d. per mile. (N.B.—This includes chauffeur, and is less than 1d. per mile above the rate given by the previous figures.) But my friend includes in his account the following most significant figures:—

Interest on car and accessories (cost £270) during first year at 5 % ...	£13	10	0
Depreciation first year	100	0	0
Interest second year on £170 ...	8	10	0
Depreciation second year	60	0	0
Total	£182	0	0

Or £91 per annum, which, on the 10,600 mileage, gives us approximately another 2d. per mile. Thus the total cost per mile is 7d.

At first sight the amount allowed for depreciation will appear too great; but could he sell his £270 car and accessories for much over £110 after doing 21,200 miles? I think he would have difficulty in getting very much more. He proposes to reduce the depreciation allowed each year. Perhaps it would simplify matters to allow, say, one-sixth of the capital outlay for depreciation per annum, but one must certainly allow something like this, as after 10,000 miles per annum for six years the car will not be worth much.

One more case I should like to give is that of a medical relative of mine who drives his own car, a small Grégoire. He tells me his running expenses are about 6d. per mile.

So that I do not think any man, driving a small car himself, can expect to get off under 6d. per mile at the lowest, if he includes reasonable depreciation, etc. If, then, the country G.P. does 8,000 miles he will be at least £200 per annum out of pocket. If a small mileage only is done, the cost per mile is sure to be a good deal greater. It would be interesting if some old Guy's men would send figures showing their expenses with horses, including total mileage and cost per mile. I fancy, from my own experience, that the man who does 8,000 miles with horses will find it costs at least £150. (I am not including the case of the man who "makes a bit" by means of his knowledge, or his friends' lack of knowledge, of horses.) Each must consider for himself whether the obvious advantages of a motor outweigh the cost, and the more or less frequent difficulties which, in the long run, are bound to occur. But I hope no one will start a motor basing his calculations as to probable cost on incomplete figures, which omit depreciation allowance, or which are supplied by the enthusiastic owner of a car, the parts of which are as yet in perfect order.

L. N.

Reviews.

The price of books submitted for review should in every case be stated.

Common Affections of the Liver. By W. Hale White, M.D., F.R.C.P. (James Nisbet & Co.) Price 4s. 6d. net.

A book bearing on its title-page the familiar name of our senior physician certainly needs no recommendation to Guy's men, but perhaps it is none the less desirable on that account to call attention to it. In this work, which is the latest addition to Messrs. Nisbet's series of "Modern Clinics," Dr. Hale White has arranged in book-form his notes of lectures on the clinical aspects of the commoner affections of the liver, the rarer diseases being "only mentioned briefly," and the "excessively unusual" (except, perhaps, aneurysm of the hepatic artery) being "omitted altogether."

After chapters on wandering liver and the general aspects of jaundice, the author deals with suppuration within and around the liver, cirrhosis, syphilis, perihepatitis, malignant disease, tuberculosis, actinomycosis, hydatid disease, and acute yellow atrophy. The affections of the gall-bladder and bile ducts, being the subject of another volume in the series, are not discussed here. The chapters on cirrhosis and perihepatitis, in view of Dr. Hale White's well-known views on those diseases, will probably excite special interest, but the book is thoroughly readable and suggestive throughout, and will be a valuable addition to the library of the student and practitioner alike. Moreover, it is printed in good type on light paper, making it a pleasure to read and to hold, and is free from illustrations, which in these days are too often introduced quite unnecessarily into medical and surgical and every other kind of book.

Periodicals received.—St. Mary's Hospital Gazette; The Hospital; Manchester Medical Students' Gazette; Durham College of Medicine Gazette; The Stethoscope; South African Medical Record; Polyclinic; Calcutta Medical Journal; Middlesex Hospital Journal; St. Thomas's Hospital Gazette; The Clinical Journal.

Books Received.—Macdonald's The Bearings of Chronic Diseases of the Heart on Pregnancy, Parturition, and Childbed; Ballantyne's Antenatal Pathology and Hygiene; Osler's System of Medicine, vol. I. to IV.; Braun's Animal Parasites of Man; Rose and Carless' Surgery; Buckmaster's The Morphology of Normal and Pathological Blood; Dr. Hale White's Common Affections of the Liver; Dr. Taylor's Harveian Oration, for 1907; Moullin's Inflammation of the Appendix; Lucas's First Lines in Dispensing; Lauder Brunton's Therapeutics of the Circulation; Lathom's Dictionary of Treatment; Quain's Anatomy, vol. III., part I., Neurology; Emery's Clinical Bacteriology and Hæmatology.

Sport.

Rugby Football.

GUY'S v. ROSSLYN PARK.

Played at Richmond on Saturday, October 17th, on a ground well suited for a fast game, but in a close muggy atmosphere that seemed to tell on the players, especially the hospital forwards, in a marked degree. Jones, Archer, and Moberley did not turn out, Duke, Elliott, and Sprague coming into the vacant places. The game, from the hospital point of view, was disappointing, as after the good form shown in the first half, during which Guy's secured their 5 points, it was somewhat of a shock to find Rosslyn Park slowly, but nevertheless surely, gain the upper hand, and had their backs played as well as their forwards, and taken advantage of their openings, Guy's would have left the field many more points behind. A fine run by Stringer, almost immediately after the kick-off, spelt danger, but the Park got safely out of the trouble, although for a time our forwards were literally all over the home side. A well-judged kick by Stokes found touch by the corner flag, and from a scrum just after, Stokes gained a clever try, by the posts, for Medlock to convert. For a long while, Guy's had the best of it, but Lee and Lacey constantly missed passes, so that open play gained but little ground. Just before half-time a forward rush by the Park enabled Wells to dash for the line, but Crook's vigorous tackling prevented a score at the moment, although, just after, another maul by the left-hand corner flag ended in Macfarlane scoring wide out. Half-time, 5 points to 3 in Guy's favour.

On resuming, Rosslyn Park pressed, and within five minutes, passing by Dixon, Muirhead, and Philcox enabled the last-named to ground a try. From the drop-out loose play ensued, and then a strong dribble by two or three home forwards rushed the ball to the line; Duke bowled over the man with the ball, but Moore was in close attendance, and put on the third try. Neither of these last two tries was converted. The hospital did not shine after this; the forwards had apparently shot their bolt by their earlier efforts, and the backs never settled down to systematic attack. Play was of a give-and-take order, relieved by fine defensive work on the part of Lee and Lacey. Final score: Rosslyn Park, 9 points; Guy's, 5 points. Team:—

Guy's.—H. L. Duke (back); L. B. Stringer, H. Lee, G. E. W. Lacey, L. Stokes (three-quarters); A. H. Medlock, L. C. Cane (halves); H. R. Mullins, G. R. Hind, A. H. Crook, H. Hoby, G. H. Stranach, E. L. Elliott, C. G. Sprague, – Roberts (forwards).

Remarks.—After the first half, the side fell off from their previous display. Perhaps lack of condition was the reason, but there was an absence of enthusiasm, dash, and vim, that seemed, with one or two exceptions, to pervade the whole side. Hoby and Stranach played well; the former's splendid following up might well be imitated by the other forwards. Medlock missed Saner. The centres fumbled their passes badly, but their defence was good. Stokes must learn to go for his man, and Duke was uncertain.

GUY'S v. CAMBRIDGE UNIVERSITY.

Played at Honor Oak Park on Wednesday, October 21, before a splendid and enthusiatic crowd, on a turf ideally conducive to a fast game. The north-easterly wind favoured the visitors during the first half, but gradually died down, so that on change of ends Guy's could not claim so much advantage. The Varsity brought up their best available side, including eleven Blues, whilst Guy's had also their best team out with the exception of Moberley in the pack. Sprague deputised in worthy fashion, but he has rather a tendency to kick too hard in the loose.

Quite early in the game MacLeod scored a try. Receiving the ball after a passing bout, he dashed over brilliantly, but could not convert. For quite twenty minutes the "Varsity" attacked hard, but some brilliant defensive work by Lee, who tackled in his best style, kept them out. The game then settled in mid-field, where the home pack began to control the scrum, and heeling much better than in former games, Cane was able to send out passes rapidly. Medlock, probably a little nervous, "mulled" one or two awkwardly, but he made ample amends soon after by running over prettily after feinting to pass, with a try which he failed to convert.

On resuming play, Burton got away at a great pace, but Stringer caught him with a safe tackle, a feat he repeated on any and every occasion that Burton looked dangerous. On the other wing long and fast in-and-out passing, beautifully executed by Wright and Macleod, got the leather right down the field when Lacy effectually stopped the movement. Both sides worked hard for the lead, and Guy's forwards dribbled down beyond half-way, when Hoby started a brilliant passing run, almost all the back division handling, and Stokes, going over in good style, capped the movement. Stokes's kick went wide.

Half-time. Guy's six points, Cambridge three.

Cambridge, refreshed by the short interval, and admirably led by Lely, for a time took charge of the game, and from a scrum close on the line, Holloway got a try. Macleod missed the kick, and thus once again the pegging was level; but not for long, as a strong forward movement on the part of Chapman, Tudsberry and Lely, ended in Lely touching down. Again Macleod missed. Guy's now began to wake up, and with only fifteen minutes to go, played for all they were worth, and the forwards, especially Hoby, Archer, Crook and Stranach, worked like Trojans. The game was well inside the Cambridge half when Jones secured, and cutting through his opponents, sent in Hoby with an unconverted try, making the scores equal once again. Excitement ran high indeed, as Stranach threw himself over the line with an apparent try, but the referee ruled otherwise, and a scrum followed. Guy's were now playing grandly; passing accurately and quickly the ball reached Lee, but he hung on and was tackled, with Stokes well placed.

Almost immediately after, another brilliant series of passes by the hospital halves and threes got the ball out to Stokes, who raced for the line and landed a fine try amid tremendous cheering. Stokes's kick failed to convert, and a splendid game ended in the hospital's favour by four tries to three. Team:—

Guy's.—G. E. W. Lacey (back); L. B. Stringer, H. Lee, J. P. Jones, L. Stokes (three-quarters); L. C. W. Cane, C. H. Medlock (halves); H. R. Mullins, H. Archer, G. R. Hind, A. H. Crook, H. Hoby, H. Stranach, C. H. Roberts, C. G. Sprague (forwards).

Referee: Mr. Sloper.

Remarks.—The whole side played splendidly, Stokes takes his passes well and goes for the line in most determined fashion; he would add much to his play if he would tackle low. J. P. Jones marked MacLeod and quite prevented that player getting away in those great individual efforts of his of which one so often reads. Lee and Lacey were quite sound, and Stringer did a lot of good work; both halves were decidedly good. The forwards are to be congratulated on a great display. Hoby especially added greatly to his laurels as a player, and was indeed useful both with hands and feet.

GUY'S v U.C.S. OLD BOYS.

This match was played on October 24th, at Honor Oak Park. The hospital carried too many guns fore and aft for the U.C.S. Old Boys, who are not so strong a combination as in former years, but notwithstanding the fact that they lost by 36 points to nil, they played throughout a sporting and plucky game.

The game had not been in progress long before Jones cut out an opening for Stokes to score wide out. Stokes majorised with a fine kick, and a little later kicked another goal from a far-out try, gained by Stringer. Guy's heeled out constantly, obeying the constant exhortation of Mullens to "have that ball back," and consequently Medlock was putting his "threes" in constant motion. Jones gave a great exhibition, and made openings most skilfully for his wing man, Stokes, who took full advantage of them and shortly after added an unconverted try. Stranach, who is proving himself a most useful forward, gained the fourth try, and then some perfect handling by Monaghan, Medlock, Covell, Jones and Stokes enabled the latter to add a fifth try. Stokes made good attempts at goaling in each case, but was not successful. At half-time, Guy's were 19 points ahead.

The second part of the game was a repetition of the first. Covell, who played an improved game, gained a try, followed a little later by Stokes and also by Monaghan; Medlock managed to add extra points to Monaghan's try. Just afterwards Roberts crossed the line, and before the finish Monaghan again scored; these last two kicks were taken by Moberley, but failed. Some of the high scoring must be attributed to Medlock's good judgment in getting his three-quarter line always moving at top speed before he parted with the ball. Final score: Guy's, 3 goals 7 tries (36 points); U.C.S. Old Boys, Nil. Team:—

Guy's.—G. E. W. Lacey (Back); L. B. Stringer, G. C. Covell, J. P. Jones, L. Stokes (three-quarters); C. H. Medlock, P. J. Monaghan (halves); H. R. Mullins, H. Hoby, A. Moberley, H. Stranach, C. H. Roberts, E. L. Elliott, C. G. Sprague, T. D. Stout (forwards). Referee, Mr. Calver.

Remarks.—The U.C.S. Old Boys were weak, hence too much must not be made of the big score, yet the home side achieved a good win, considering four or five men were absent. J. P. Jones gave an ideal exhibition of centre three-quarter play; his openings for Stokes were the feature of the game. Covell kept Stringer too cramped to give him full opportunity. The forwards were always masters of the situation; it is a pity they do not follow up better; this part of the game generally being left to one or two of the more energetic members of the pack. It would also be an advantage if the try-getters occasionally endeavoured to get round a bit further towards the posts; more of the tries on Saturday might have been converted if a little more effort had been made in this direction.

Association Football.

GUY'S v. EMERITI.

This match was played at Honor Oak Park on Wednesday, October 14th, in ideal weather. Guy's lost the toss, and started against a powerful sun. The Emeriti first attacked, their inside forwards playing well together, but were prevented from scoring by the vigorous efforts of our defence. Our forwards, weakened by the absence of Birks and King, put extremely little vim into the game, and gave the opposing defence very little trouble. Cook, at outside right, made one or two good runs along the wing, but no score resulted from his centres. Our opponents were having slightly the better of the game, and opened the scoring about twenty minutes after the kick-off. Our defence, of whom Bastard and Humm were in splendid form, found plenty to do, as our inside forwards rarely fell back to give them any assistance. Wood, in goal, was playing a great game, making some magnificent saves. Half-time arrived with the score 1—0 against us.

The second half was practically a repetition of the first, our forwards showing no particular desire to score, and apparently being quite content with forcing a stray corner or two. The halves and backs worked hard, and held their opponents well in hand during the greater part of the second half, but about twenty minutes from the end their inside right got clear away, and scored their second goal. Team:—

Guy's.—C. A. Wood (goal); H. R. Bastard, C. H. Mills (backs); K. H. Hole, P. S. Humm, H. V. Gibbons (halves); W. W. Cook, C. Witts, H. Renton, T. L. Jones, J. McManus (forwards).

GUY'S 2nd XI. v. DULWICH WOOD.

Surrey Junior Cup Tie (Replay).

This Cup tie was replayed at Honor Oak on Saturday, October 24th, and resulted in a win for the Hospital by 3 goals to 1. The score very fairly represented the game,

for although Guy's did most of the pressing, the display of our forwards in front of goal was very poor. Guy's again started with the sun at their backs, and in the first half scored two goals through Harrison and Mitchell. Crossing over with the score 2—nil in our favour we failed to improve. Dulwich were several times dangerous, and in one of their rushes they scored their only goal, Rook being yards away from the goal at the time. Before time, however, Guy's scored again, a magnificent centre from Rice being rushed through after being fumbled by our opponents' goal-keeper. This is the first time for several years that Guy's has passed even the first round of these Cup ties. With a little more keenness we might go much further in them.

Remarks.—With the exception of Johnson, Keer and Townrow, the whole team played badly, especially the forwards, whose combination was almost nil, and whose ability to shoot straight was still less. Rice at outside right might have done better had he had more assistance and fewer wild passes from his partner. Wain should go straight for goal instead of turning circles in mid-field, and both he and Harrison should "bustle" more. Mitchell's centering was very wild. Rook gave away a goal by running out too freely, which spoilt what would otherwise have been a good performance. Team :—

Guy's.—H. C. Rook (goal); W. Johnson, K. J. Keer (backs); C. E. Reckitt, V. Townrow, J. A. Edmond (half-backs); C. E. Rice, W. Wain, R. Harrison, T. L. Jones, D. A. Mitchell (forwards).

Hockey.

FIXTURES FOR 1908—1909.

November	4.	Enfield.
"	18.	R.N.C. Greenwich.
"	25.	IXth Norfolk Regiment.
December	2.	Banstead.
"	9.	Woolwich Garrison.
January	20.	Royal Masonic School.
"	27.	Banstead.
February	3.	K.G.S. Old Boys.
"	10.	Enfield.
"	17.	H.A.C.
"	24.	A Bromley XI.
March	3.	K.G.S. Old Boys.
"	16.	R.N.C. Greenwich.
"	24.	Woolwich Garrison.

Golf.

An arrangement has been made with the West Essex Golf Club, by which members of the Guy's Hospital Golfing Society may become five-day members of the club on payment of an annual subscription of £2 2s. without entrance fee. Such members may play on Saturdays and Sundays on payment of a daily green fee of 2s. 6d.

Members of the Society may play at West Essex any day (except Sunday) at a green fee of 2s. 6d. a day. On Sundays the green fee is 5s., unless accompanied by a member, when it remains at 2s. 6d.

Will those who wish to pay the annual subscription correspond with the Secretary of the West Essex Golf Club?

Pass List.

University of Cambridge, October, 1908.—Tropical Medicine and Hygiene: C. A. L. Meyer. Sanitary Science: E. P. Minett.

University of London, October, 1908.—D.Sc. Examination.—Physiology: David Forsyth, M.D.

Second Conjoint Examination, October, 1908.—Anatomy and Physiology: H. L. S. Griffiths, Jap Ah Chit, F. G. Lloyd, G. Marshall, A. C. Schulenberg, A. S. Seabrooke.

From the Gazette's Special Pathologist.

R. F., Broadbolton.—Blood serum, inoculated with this swab, gave after incubation a culture containing micrococci, including numerous streptococci. No Klebs-Löffler bacilli were found.

R. F., Broadbolton.—The sputum contains some blood-stained muco-pus, and the organisms present are the pneumococcus, the micrococcus catarrhalis and a gram-negative rod which is too small for bacillus mallei, and is probably Pfeiffer's influenza bacillus. No tubercle bacilli are found. Media inoculated with this sputum give cultures of the organisms mentioned. No colonies of the bacillus mallei are found, but we are making some further cultures, and a wire will be sent if any glanders bacilli are detected.

Further Report,—No glanders bacilli are found in further cultivations made from the sputum.

PATHOLOGIST.

Births.

ROBINSON.—On Sunday, October 18th, at 2, Mutley Park Terrace, Plymouth, the wife of Gerald Robinson, F.R.C.S., of a son.

Marriage.

BARKER—CLARKE.—On the 27th inst., at the Cathedral, Bombay, Frederic Allan Barker, M.A., Cantab., of the Indian Medical Service, to Amy Helen Clarke (Sister Amy), late of Guy's Hospital. (By cable.)

Eds.—L. M. & A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

November.

Sat. 14. 1st XV. v. London Welsh (Home).
1st XI. v. Emeriti (Home).
Physical Society, Clinical Meeting, 8 p.m. (President: T. D. M. Stout.)

Mon. 16. Clinical Lecture by Mr. Iredell (Actinotherapeutics), 1.15 p.m.

Thur. 19. Messrs. Dunn and Rowlands' Take-in (Messrs. Hinde and Perkins).

Sat. 21. 1st XV. v. London Irish (Home).
2nd XV. v. Tunbridge Town (Away).
1st XI. v. Wanderers (Away).
2nd XI. v. East London College (Home).

Mon. 23. Clinical Lecture by Mr. Fagge (Otology), 1.15 p.m.

Wed. 25. Physical Society, Paper by E. P. Minett. (President: P. P. Laidlaw), 8 p.m.

Thur. 26. Sir Alfred Fripp and Mr. Turner's Take-in (Messrs. Syms and Price).

Passim.

EVERY year, in the very early spring, some enthusiast writes to the papers to announce that he has heard the cuckoo for the first time; a few days after the twenty-first of June, the people who look on the dark side of things begin to say that the "evenings are drawing in," and it will soon be winter. Similarly, about this time of the year, it becomes the annual duty of the Passimist to discern the earliest signs and omens of approaching Christmas. At present we have encountered but one harbinger of the coming festive season in the form of an O.P.O. collecting for the Out-patients' Tea, but the brains of those who sacrifice themselves in order to make our hospital Christmas the splendid success it usually is, are no doubt already beginning to evolve their schemes of decoration and entertainment. Mr. Dryland and his colleagues may be trusted to maintain, even if they do not excel, the high standard set in previous years.

A CONFERENCE was recently held at the University of London to discuss the advisability of forming among students of the University a contingent of the Officers' Training Corps, of which we published some particulars in our last issue. Representatives of the War Office explained the scheme and answered questions, and the Provost of University College then moved a resolution requesting the Senate to take the necessary steps towards the formation of such a contingent. Courses of instruction in military subjects, "intended primarily for students preparing for the commissions in the Army for which the University nominates," are to be given at the University, and the "inaugural lectures, to which admission will be free, will be delivered in the week beginning Monday, November 23rd, as follows: — By Colonel Sawyer—Military History and Strategy, Monday, at 5.30 p.m.; Military Topography, Monday, at 6.30 p.m.; Tactics, Thursday, at 5.30 p.m.; Military Law and Administration, Thursday, at 6.30 p.m. By Colonel Maude—Military Engineering, Wednesday, at 5.30 p.m. None of the courses will be continued after the first lecture unless ten students present themselves in the subject." It is to be hoped that the proviso expressed in the last sentence will not be necessary.

In recording in our last issue the success of Dr. David Forsyth in obtaining the London D.Sc. degree, we omitted to mention, in addition, that the Rogers prize of £100, awarded by the London University, has been divided equally between Dr. Forsyth and another gentleman. Dr. Forsyth's essay dealt with the anatomy, physiology, and pathology of the thyroid and para-thyroid glands.

A correspondent writes asking whether there is any accommodation during matches for motor-cars on the ground at Honor Oak Park, as he believes many old Guy's men would attend the matches if they could be sure of finding room inside the ground for their cars. We should, therefore, like to assure the many old Guy's men who are now motorists that they need have no hesitation on this score in coming to the matches by motor. At the recent Cambridge match on our ground, a number of motor-cars were to be seen waiting safely inside the gates, but there would have been ample room for three or four times as many.

We are asked to remind our readers that the various classes in connection with the Pavy Gymnasium are now in full swing again. As Guy's men are so favoured by opportunities for instruction and practice in these branches of sport, it is a great pity if anyone who would otherwise use the gymnasium does not do so for lack of knowledge of those opportunities. We would therefore remind members of the Clubs' Union, who are all, of course, entitled to use the gymnasium, that the Boxing Instructor attends on Tuesdays, at 4 p.m.; the Teacher of Gymnastics on Thursdays, at 4; and the Teacher of Fencing on Fridays, at 4.30.

At a meeting of the Physical Society held on Wednesday, October 28th, an excellent paper on "Carcinoma of the Liver" was read by Mr. F. J. Wheeler. We hope to publish this paper in a future number.

We are asked to announce that the fifth annual dinner of the Centurion Club will be held at the Gaiety Restaurant, Strand, on Wednesday, the 18th inst., at 7.30. This date has been arranged in order that country members may combine business with pleasure. Those members who intend to be present are asked to communicate at once with the Secretary, Mr. Herbert Wallace, Foulden Lodge, 133, Upper Clapton Road, N.E.

The recent meeting of the Students' Club brought to light the fact that the Library in the College is not used so much as it might well be. On account both of the intrinsic value and convenience of the Library and of the annual expenditure in connection with it, it is highly desirable that new members should know and take advantage of its existence. The Librarian attends in the Reading Room on five days in the week, between five and six o'clock, to give out the books. The Library, the nucleus of which was formed by a present of books from the late Mr. Gladstone, is in connection with Mudie's, and a list of the new books in circulation is posted up in the Reading Room. Catalogues can be obtained or consulted on application to the Librarian, who will also supply any further information.

We regret to announce the deaths, which have recently occurred, of two old Guy's men. Dr. Cuthbert Collingwood, M.A., B.M., F.L.S., M.R.C.P., of Lewisham, died on October 20th, in his eighty-second year. He was educated at Christ Church, Oxford, at Guy's, and also at Edinburgh University. He graduated in 1849, and ten years later became a Member of the Royal College of Physicians, after which he devoted himself more particularly to the study of botany. He lectured on this subject during the years 1858–1866 at the Liverpool Medical School, and he afterwards made a scientific voyage to the Far East for the purpose of studying marine zoology, and recorded his researches in a volume entitled, "Rambles of a Naturalist on the Shores and Waters of the China Seas." Dr. Collingwood was thus one of a long line of medical men who have made natural science their devoted study, and who have maintained the traditional medieval reputation of the physician as the chief pioneer in scientific progress.

ERNEST RICHARD BARNES ARCHER, M.R.C.S. Eng., L.S.A., died at his residence at Walthamstow on October 19th, in his forty-seventh year. He was a son of Staff-Surgeon Leslie Archer, R.N. (retired), of Stoke, Plymouth. He received his medical education at Guy's, and qualified in 1887, after which he resided at Plymouth, where he won great popularity. Later he moved to Walthamstow, and there he continued to practise till his death.

Guy's Hospital Debating Society.

A meeting of the above Society was held on Nov. 7th, Mr. A. R. Thompson in the Chair; 75 members were present. The minutes of the previous meeting having been read and confirmed, and some private business transacted, Mr. Stephens moved, "That in the opinion of this House the modern Music Hall exerts a beneficial influence on Society." Mr. Mackenzie opposed; Mr. Gool seconded the motion, and Mr. Wall the opposition. A long and interesting discussion ensued, during which the ten o'clock rule was suspended, and Messrs. Gardiner, Levinson, Schlesinger, Reckitt, George, Reynolds, Layton, May, Stewart, Edey, D. Stout, D. R. Jones, Ingram, Berry, Hinde, Adams, Hoby, and Thompson spoke. When the division was taken, 30 members voted for, and 35 against the motion, which was therefore declared lost.

The next debate will be held on December 5th on the motion "That this House believes that the pursuit of Science diminishes one's appreciation of Art." In addition some important private business will come up for discussion.

Pass List.

FINAL CONJOINT EXAMINATION, OCTOBER, 1908.—Medicine, Surgery and Midwifery: *A. H. Crook, *H. E. Perkins. Medicine and Surgery: L. W. Evans, *H. C. Lucey, *J. Walker. Medicine and Midwifery: H. W. Heasman, H. E. H. Mitchell, *C. A. Wood. Surgery and Midwifery: *S. J. Darke. Medicine only: M. M. Adams, D. Allan, H. Lee, H. R. Mullins, *C. M. Plumptre, C. W. R. Preston, *A. H. V. St. John. Surgery only: *F. R. L. Atkins, *M. E. Ball, *M. R. Dobson, *F. Holcombe Fuller, *H. N. Greaves, *E. L. W. Mandel, *M. K. Nelson, *W. G. Pinching, *P. Seymour Price, *L. L. C. Reynolds. Midwifery only: M. M. Cowasjee, H. L. Duke, *J. W. Grice, D. Isaacs, A. E. Rayner, *D. Reynolds, D. C. Roberts, *R. P. M. Roberts, A. D. Vernon-Taylor, C. H. Mills.

* Denotes completion of examination.

Change of Address.

Fleet-Surgeon W. J. Bearblock, R.N., from H.M.S. *Gibraltar*, to 14, Stoke Terrace, Stoke, Devonport.

Mr. A. Reginald F. Evershed, from 19 to 13, Harley Street, W.

Dr. E. J. F. Hardenberg, from "Glendale," Station Road, Chingford, to "Cliveden," Forest Avenue, Chingford. Teleph. 64 Chingford.

Dr. David H. Trail, from 13, Florence Place, Falmouth, to "Darjeeling," Woodlane, Falmouth.

Dr. S. M. Wells, from Valparaiso, Chile, to Casilla, 924, Lima, Peru.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Papers by Guy's Men.

Constipation. By Arthur F. Hertz, M.D.—*British Medical Journal*, October 10th, 1908.

The Treatment of Inoperable Cancer. By Henry Morris, M.B., F.R.C.S.—*The Lancet*, 3rd October, 1908.

The Influence of Oxygen upon Respiration. By M. S. Pembrey and F. Cook.—*The Journal of Physiology*, vol. xxxvii, part 2, 1908.

The Complex Nature of Typhoid Etiology and the *Rôle* played by Animals and Man in the Spread of the Typhoid Group of Diseases. By Major J. C. B. Statham, R.A.M.C., *Journal R.A.M.C.*, October, 1908.

A Clinical Lecture on a Case of Femoral Aneurysm treated by Excision of the Sac. By C. H. Fagge, M.S. Lond., F.R.C.S. Eng.—*The Clinical Journal*, October 21st, 1908.

The Prognosis of Infantile Convulsions. By R. Oswald Moon, M.A., M.D. Oxon.—*British Medical Journal*, 17th October, 1908.

A Case of Implantation of the Ureters into the Rectum for Extroversion of the Bladder in a Woman, by a modified Peters's Operation. By R. Lawford Knaggs, M.C. Cantab., F.R.C.S. Eng.—*Ibid.*, 24th October, 1908.

Prolapse of the Uterus. By Thomas G. Stevens, M.D., M.R.C.P. Lond., F.R.C.S. Eng.

Œdème Persistant Héréditaire Des Jambes avec Exacerbations Aigues. By Dr. W. B. Hope and Dr. Herbert French.—*Nouvelle Iconographie de la Salpétrière*, No. 3, Mai–Jun, 1908.

The Mitchell Banks Memorial Lecture. By Henry Morris, F.R.C.S.—*British Medical Journal*, 7th November, 1908.

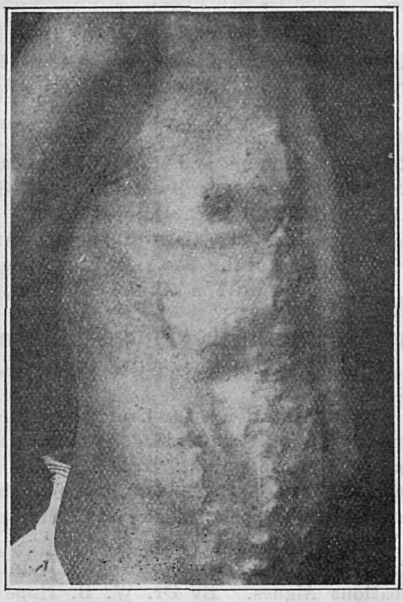
The Value of Taking the Specific Gravity of the Blood during Saline Transfusion in Cholera. By Captain E. J. O'Meara, F.R.C.S. Eng., Indian Medical Service. *Indian Medical Gazette*, October, 1908.

Multiple Diverticula of the Sigmoid Flexure. By W. H. Maxwell Telling, M.D. Lond., M.R.C.P. Lond.—*British Medical Journal*, 31st October, 1908.

Some Recent Work in Diseases of Children. By George F. Still, M.A., M.D., F.R.C.P.—*The Practitioner*, November, 1903.

Some Interesting Cases from Clinical.

I. *A case of syphilitic mediastinitis with paralysis of the left vocal cord and obliteration of the superior vena cava dating from seventeen years ago.*—A sawyer, 64 years of age, was admitted into Clinical, under Dr. Hertz, in September, for shortness of breath. In 1891 he was in Philip ward, under Dr. Goodhart, for shortness of breath and cough. He gave a history of syphilis twenty years previous to this admission, but he had had no further symptoms of the disease until three months before his first admission into the hospital. Then in a few days his left arm became swollen and painful, and he complained of pins and needles. This was soon accompanied by a swelling of the left side of the face, which was also blue and painful.



On admission he had numerous dilated veins on his chest and abdomen; the veins in the neck and left arm were also very distended. The left vocal cord was paralysed, but the right cord could be abducted sufficiently for distinct phonation. Both sides of his chest were full of coarse râles and rhonchi.

He stayed in the hospital for three months, during which he had twelve attacks of substernal pain, dyspnœa and cyanosis, after each of which he was very much collapsed, but revived with stimulants. Several of these attacks were associated with a brassy cough, and on some occasions there was inability to swallow anything but small amounts of fluids for a few days after; the distended neck and arm veins gradually diminished in size and the thoracic and abdominal veins increased. He finally went out, feeling quite well. A diagnosis of gummatous mediastinitis, with thrombosis of the superior vena cava and involvement of the recurrent laryngeal nerve in the scar, was made.

In 1892 he was admitted again under Dr. Pitt for hæmoptysis; his physical condition was unaltered. The exact cause of his hæmoptysis was not ascertained. From 1892 to 1897 he continued at his work, and, save for occasional attacks of hæmoptysis and dyspnœa, he managed to exist fairly comfortably.

In 1899 he came in again under Dr. Pitt for pain in the right arm, back and precordial area. He was again given potassium iodide, and his symptoms gradually disappeared.

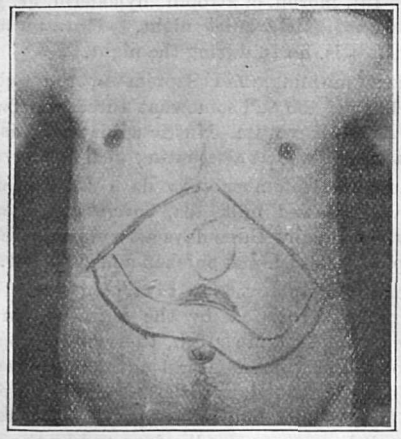
Since 1899 he has lived by selling flowers, and has been exposed to very inclement weather, and has often had insufficient food. Any severe manual labour brought on attacks of pain and dyspnœa. Despite the vicissitudes to which he has been subjected, he is still a fairly hale old man. The greatly distended veins of the chest and abdomen, in which the blood flows in a *downward* direction, are unaltered and are well seen in the two photographs. His left vocal cord is completely paralysed, and in spite of the extensive lesion that must have once been present in the mediastinum, no abnormal shadow was seen with the X-rays.

II. *A case of gumma hepatis, which rapidly disappeared under treatment.*—A man, aged 35, was admitted into Clinical, under Dr. Hertz, on the 14th September, 1908, for an epigastric tumour associated with pain. He had a chancre sixteen years ago, followed by well-marked

symptoms of secondary syphilis, and was under observation at King's College Hospital for eighteen months, during which he took mercurial pills. Six years after the disappearance of the chancre, another appeared on the same site three weeks after connection. It was pronounced by Mr. Carless, of King's, to be an undoubted instance of a second chancre appearing after a previous infection. Patient only had local treatment for this sore; it disappeared in fourteen days and no secondary symptoms developed.

One month before coming up to the hospital patient had a severe shivering fit with pains in the limbs, headache and a temperature of 103°. He was sent away for a short holiday, and came back complaining of pain in the stomach. An examination revealed an abdominal tumour, and patient came up to the hospital and was admitted.

On admission the pulse, temperature and respiration were normal. A rounded swelling, three inches in diameter, was visible in the epigastric region; the skin covering it was normal. On palpation, considerable tenderness was present over an area corresponding to the



circle in the photograph, the area representing the maximum convexity of the swelling. There was no local evidence of inflammation, and there was no fluctuation. The swelling was obviously a part of a greatly enlarged liver, the size of which is shown by the broad line in the photograph. Its edge was regular, firm and hard. No lumps beyond that already referred to, and no soft areas could be felt. Towards the extreme left, the gastric resonance was obtainable through the liver. The rest of the abdominal contents seemed normal. A well-marked saphena varix of the left leg and pigmented syphilitic scars on both legs were present. Otherwise nothing abnormal was found. The diagnosis was considered to lie between malignant disease, abscess, hydatid cyst and gumma of the liver. The rarity of primary malignant disease, and the entire absence of any evidence of a primary focus, rendered the first idea unlikely. A blood-count showed the leucocytes to number 15,000: this, together with the absence of fluctuation and the quite normal temperature chart, were thought sufficient to exclude an abscess. Not a single eosinophile leucocyte could be detected in the slide, so that a hydatid cyst seemed improbable. In consideration of the strong syphilitic history, a gumma of the liver was diagnosed. With this idea, 100 grains of potassium iodide a day were given in large quantities of milk, together with a drachm of liq. hydrarg. perchlor. Patient took this quite well, and by the second day a decrease in the size of the tumour was already appreciable. The tenderness, which must have been due to local peritonitis, completely disappeared by the fifth day. By the eighth day a depression in the middle line, near where the projecting mass had been, could be felt, indicating that the gumma was being replaced by contracting scar tissue. On the tenth day the liver had diminished to the size shown by the upper line in the photograph, leaving a depression in the lower border of the liver in the middle line, in which the ends of three fingers could be placed.

The case is remarkable for the rapidity with which a large gumma of the liver was replaced under antisyphilitic treatment by scar tissue. An irregular liver from old syphilitic scarring is not uncommonly met with, but it is very exceptional to have an opportunity of watching its formation from a recently-formed gumma. H. E. P.

III. Albert R., æt. 16, was admitted on August 22nd for abdominal pain and vomiting. He is a messenger boy, and three days previously first complained of abdominal pain which made him feel faint, but was not sufficiently severe to cause him to absent himself from his work. His bowels were opened several times with purgatives, but the condition was not relieved, and on the next day (August 20th) he had an exacerbation of pain so acute and severe as to cause him to fall to the floor and cry aloud. Shortly afterwards he vomited, and the vomiting and pain continued up to time of admission to hospital.

On admission the pulse was 84, temperature 98°, and respirations 24. He was a pallid youth with a wan and haggard appearance, groaning from time to time in pain. The tongue was covered with a brown fur and somewhat dry; breath not foul. The abdomen was not distended, but was very rigid, did not move on respiration, and was tender all over on the lightest palpation. The maximum tenderness appeared to be over the iliac and pelvic regions. Moveable dulness in the flanks, liver dulness not diminished, nothing abnormal felt *per rectum*. Urine, sp. gr. 1030; high coloured. Fulminating appendicitis with general peritonitis was diagnosed.

An enema saponis was ordered and followed by slow infusion of ʒxvi. of saline *per rectum*. Patient was then anæsthetised, and the abdomen opened in the lower part of the right linea semilunaris, pus at once escaping from the incision. The appendix was found to be gangrenous in the terminal third, which contained a soft concretion of the size, shape and colour of an orange pip. The organ was removed. No actual point of perforation was demonstrable. The pus was found to be chiefly in

the iliac and pelvic regions, but all the rest of the peritoneum was hyperæmic and injected. There was no attempt whatever at localisation. The pus was removed by swabbing, and a counter-incision made in the right loin; through this a long rubber drainage tube with gauze wick and petticoat was passed across the abdomen and the incision in the linea semilunaris completely closed.

The operation lasted about half an hour, and towards the end patient was given injec. strych. hypoderm. ɱv. On returning to bed he was placed in a semi-upright position, and was given ernutin ɱx. hypodermically, and a subcutaneous infusion of a pint and a half of saline. Later he had injec. morph. hypoderm. gr. ¼ to ensure his keeping quiet.

He passed a peaceful night, and the following morning the pulse and temperature were normal, the abdomen no longer rigid and tender, and good drainage was proceeding. The tube was removed and shortened on the third day after the operation; patient was then talking brightly and his face had lost the anxious look which it wore on admission.

During the night of August 30th patient was sick four times and in the morning his condition had evidently changed for the worse. His face looked pinched and pale, and he was depressed in spirits. The abdomen was distended and rigid, tender on palpation over the lower half and only moving slightly on respiration. On rectal examination, an indefinite tender mass could be felt to the right and in front of the rectum.

Peristalsis observable. Leucocytosis 30,000. Temperature 97°, Pulse 96. Respiration 24.

It was thought that patient had developed a residual abscess, and at the operation the lower part of the incision in the right linea semilunaris was opened up, and pus evacuated from a plane anterior to the peritoneum. The latter was then opened, and the pelvis explored with the finger, but nothing was found. Drainage tube inserted.

Patient was not sick for six hours after the anæsthetic, but at the end of that time he suddenly vomited a porringer full of brown fluid material with a distinct fæcal odour. This seemed to relieve him, but again, in about six hours time, he vomited material of a similar nature and amount. The abdomen was distended, tympanitic and tender, and patient was complaining of the tightness of his bandages. A turpentine enema was given without relief, and patient's condition grew worse. The pulse was weak, face much sunken, lips and tongue dry and caked, and the breath very foul. Distended coils of small intestine with peristalsis were observed. Obstruction in the lower part of the small intestine was diagnosed. Patient was given a pint of saline per rectum and ernutin ɱx. hypodermically, and then anæsthetised with A.C.E.

The previous incisions were packed off with gauze, and the abdomen opened slightly to the left of the middle line. Numerous coils of enormously distended small intestine at once presented. A hand was passed in and a cautious search for the cause of obstruction made without satisfactory result. The incision was therefore lengthened, several coils allowed to escape, and a further examination made. No definite constriction was found, but a mass of adhesions about the lower end of the ileum which appeared to be the cause of the obstruction were separated. Following on this prolonged handling of gut, patient was very collapsed, and was given ernutin ɱv., and strychnine ɱiij. hypodermically. A piece of distended gut, about 3 feet from ileocæcal valve was then clamped, incised, and a Paul's tube inserted. A large quantity of fluid fæcal material was then drained off. The intestines were douched with hot saline and returned to the abdomen. Two large rubber drainage tubes with gauze wicks inserted, and the wound packed with gauze, the loop of gut with the Paul's tube being left just protruding. Patient was then put back to bed very collapsed. He was at once propped into a quarter-sitting position, and during the next hour received a pint of saline subcutaneously and another pint *per rectum*, an ounce of brandy being added to each pint of saline. After this, patient's pulse steadied to 100 and was of good volume. Inj. morph. et atropin. hypoderm. gr. ⅓ given; patient passed fairly quiet night. Ernutin ɱx subcutaneously 4tis. horis. during the night.

The next morning, 2nd September, the pulse was between 120 and 130 and somewhat thready. Two pints of saline given per rectum. Nutrient enemata 8tis. horis. Rectal salines 8tis. horis alternating with former.

On the 3rd September (two days after operation), patient was allowed milk, tea, bovril and bread-and-butter by mouth, and three days after nutrient enemata were stopped, and fish and chicken added to diet.

His condition improved up to a point, but the skin became much excoriated by the irritating intestinal discharges. On September 9th, therefore, an operation was performed in which a lateral anastomosis was made between the gut about four inches above the enterotomy and the transverse colon. The operation was rendered very difficult by numerous adhesions and by the œdematous and rotten condition of the gut wall.

Portions of gut were resected from each side of the enterotomy, and the two ends were closed and inverted by purse-string and other sutures. The divided mesentery was brought over the sealed extremities which were buried deep in the abdomen with the weak points in contact with the parietal peritoneum of the posterior abdominal wall. The abdominal wound was then closed, two small superficial drains being inserted. The operative and post-operative treatment as before.

Following this, patient made an uninterrupted recovery, and put on flesh. He finally went out to a convalescent home on October 2nd, walking with a little help, and wearing an abdominal belt. Practically linear scars, and no bulging on coughing.

This case illustrates the remarkable recuperating power of an apparently weakly individual. It is difficult

to convey in words any idea of the apparently hopeless condition of the patient up to the time of the fourth operation.

Attention may be directed to the burying of the doubtful anastomosis deep in the abdomen against the posterior parietal peritoneum. In this situation it is quickly shut off and out of harm's way. It may be noticed that no drains were put in the vicinity. Several cases have apparently failed from a too cautious drainage. The value of active anti-shock treatment, both before and after operation, is also shown.

I have to thank Dr. Hertz and Mr. Rowlands for permission to publish an account of this case.

E. L. M. L.

Appointments.

Naval and Military.

Surgeon RICHARD WILLAN, R.N., has been appointed to the *Barham*.

Major S. E. PRALL, M.B., I.M.S., is promoted to be Lieutenant-Colonel.

Territorial Force—Sanitary Service.

To be Majors:—

Surgeon-Major RICHARD JOHN BRYDEN, from the 1st Kent Royal Garrison Artillery (Volunteers).

Surgeon-Captain FRANCIS EDWARD FREMANTLE, from the Herts Imperial Yeomanry.

To be Captains:—

Surgeon-Captain CHARTERS JAMES SYMONDS, from the King's Colonial Imperial Yeomanry.

Surgeon-Captain PETER PAGET, from the 2nd (The Weald of Kent) Volunteer Battalion, The Buffs (East Kent Regiment).

Surgeon-Captain (Honorary Captain in the Army) GEORGE BLACK, from the 2nd Volunteer Battalion, The Royal Sussex Regiment.

Notices.

REVISION CLASSES IN MEDICINE.

The School Examination in Medicine for the Final Examination of the Conjoint Board, etc., in January next, will be held on Monday, November 16th, at 10 a.m., in the Committee Room, Medical Office.

The Viva Voce Examination will be held on Wednesday, November 18th, at 2 p.m. It is essential that both written and viva voce examinations be passed before admission to revision classes can be granted.

The Revision Classes in Medicine will be held in Class Room No. 3, at the following times:—Mondays, at 9.15 a.m.; Tuesdays, at 12 noon; Wednesdays, at 12 noon; commencing on Monday, November 30th.

Treatment of Hyperaesthesia of the Dentine.

CLINICAL LECTURE BY MR. E. B. DOWSETT.

GENTLEMEN,—The greatest bugbear of dental surgery—and I think you will agree with me the one point that worries you all more than any other in the Conservation Room, for it is ever with you—is sensitive dentine. It is of that I am going to speak to you now for a short time.

It has often been my experience to find students placing their sole confidence in the application of a little carbolic acid or oil of cloves, and then being disappointed with the result and hopelessly in the dark as to how to overcome the difficulty, or even sometimes, after successive applications of all the drugs in the cupboards, to find them as far off as ever from the desired result. One has often noticed, in these trying circumstances, that there has been one thing lacking, a thing, too, that one cannot speak about very much at the chair side, and that is the treatment of the patient apart from the tooth. Therefore I will speak of that first, for it is assuredly half the battle.

Now the patient so frequently comes to us in a state of fear and trembling and nervous apprehension that the slightest touch is often unconsciously magnified to hyperæsthesia of varying degrees. The very first point, therefore, when there is any trouble pending, is to reassure the patient and inspire confidence by sympathy and attention to his fears. This is one of the fundamental things of our profession. It is to the shame of the dental profession as a whole that the public still very largely associate in their minds a dental operation with considerable suffering. It should be one of our main objects to dispel this deep-rooted idea. Frankness of speech and action, allied to a great deal of tact, are the surest means of success.

Never give any unnecessary pain, but let any pain given always bear some definite purpose, and let the patient fully appreciate this. At the same time, treat the patient with all the gentleness at your command.

Never deceive anybody wilfully as to the amount of pain you are likely to inflict, or the patient's trust in you will be seriously shaken and the difficulties increased.

Remember that our patients are never at their best in our chairs, and are often at their worst. With previous pain, and possibly previous bad treatment, they often become highly overwrought and their self-control may have gone.

Use nothing but sharp instruments, and use new burrs as often as possible. Also have them warm, which is very important, in winter especially. Let all the movements in the cavity be *purposive*, and, above all, do not scrape merely for the sake of scraping, as one apparently so often sees done in the Conservation Room.

And now to speak of the actual tangible aids at our command. They form a very formidable array, and they all have, or have had, their advocates. We shall have to consider two classes of treatment—firstly, that for immediate effect, so as to be able to proceed at once; and, secondly, that for a later effect, so that another visit on the part of the patient is necessary.

One may here state at once that there is very little guide as to the choice of treatment, and it often resolves itself into trying one form after another, if necessary, until some measure of success is attained. But one can say that, with the nervous and apprehensive type of patient, there seems less hope for immediate effect, except by the more heroic methods one will mention shortly, than by taking some means for a remoter effect at a second visit, which seems, as a rule, more expeditious, for the strain of the operation, necessarily lengthened by continued applications, may tend to make matters rather worse than otherwise.

Firstly, then, for immediate effect, the simplest expedient, and the one that is nearest at hand, is a blast or two of hot air from a Chip syringe, warning the patient that it may be felt slightly, and remembering that the harder one blows the cooler is the blast, and *vice versa*. This apparently acts by dehydrating the dentinal fibrils for a short depth, and making them less capable of conducting impulses. A hot burnisher will act in a similar way, though more painful to apply. Alcohol or pure glycerine placed in the cavity for about a minute on cotton wool will, by their greed for water, serve to dehydrate the fibrils, and so will have produced the same effect in a similar manner on mopping out the cavity.

Another class of drugs acts by superficially cauterising the ends of the dentinal fibrils. Liquefied carbolic acid, alone or in combination with menthol, deliquesced zinc chloride, and 20 per cent. solution of silver nitrate may all be used for this purpose. Either of these is placed in the cavity on cotton wool, after warming slightly, and left for about a minute, and then dried out with warm air. Of these the first is generally the most satisfactory. Zinc chloride is often painful to apply, and silver nitrate may discolour the tooth.

Yet another class of drugs acts by producing cold by evaporation, and so reducing the temperature of the dentinal fibrils sufficiently to make them less capable of conducting impulses. These drugs, on account of the cold produced, can, therefore, only be employed in quite small cavities, where they are often very useful, but would be extremely painful in large cavities. The drugs used are chloroform, ether, and ethyl chloride. Each is best applied on a small pledget of cotton wool and left in the cavity till evaporated, repeating once or twice before excavating further. The ethyl chloride should be first sprayed into a small receptacle, such as a Dappen's glass.

And now we can speak of those drugs that have a direct anæsthetic action on the dentinal fibrils. All the essential oils, such as oil of cloves, cinnamon, or peppermint, have a slight anæsthetic action, but it is not very marked. They again are applied warm on cotton wool, and left for about a minute or two. Lastly, but by no means of least importance, there are cocaine hydrochloride and its allies, eucaine, stovaine and novocaine, and these may be used in several ways. The following methods of use will apply to any of these four drugs, but one can state that for merely local application cocaine is probably the best, whilst for injecting any of the latter three are preferable on account of their less toxic properties. The crystals of any of these four drugs may be deliquesced in a minimum amount of water or carbolic acid, and applied to the dentine as above. This has a variable effect, according possibly to the size and structure of the dentinal fibrils. Softened carious dentine may often be anæsthetised by pressing the solution into the enlarged tubes by precisely the same method as for pressure anæsthesia for extracting the pulp.

Some years ago a great deal was expected from cataphoresis with cocaine, a continuous current of low voltage being used with one electrode on the cocaine solution in the cavity and the patient holding the other, in order to drive the cocaine into the fibrils in the direction of the current, but little seemed to come of it, and it has now almost fallen into complete disuse.

More heroic methods than any of these may be used with cocaine and its allies, such as forcibly injecting the solution into the dentine. There are various syringes made for the purpose, such as Sapp's, Meyer's, or Willcox's. These are very powerful syringes actuated by means of

a strong screw or lever to forcibly inject the solution into the dentinal tubes. A small *counter-sunk* hole is first drilled into the dentine and the nozzle of the syringe inserted into this and then worked. The drilling of the preliminary hole is often, of course, painful, the area of dentine anæsthetised is very variable, and injury may be done to the pulp by the pressure of fluid, passing through the tubes, separating the pulp from the wall of its cavity. Although often a successful method of treatment, the above points, together with the cumbersome and somewhat alarming appearance of the instrument, make the method one that is not commendable to the ordinary practitioner.

The other heroic method of using cocaine, or one of its allies, is by injecting into the gum, the quantity used and the site of injection being just as for the extraction of the tooth, the details of procedure for which need not be mentioned here. This last method is undoubtedly one that is being used more and more on account of its much greater certainty, and from the fact that patients having once experienced it, request its further use. There is one danger, however, that must be carefully attended to, and that is the risk of opening the pulp cavity inadvertently, as the pulp is, as a rule, perfectly anæsthetised, and therefore a careful watch must be kept on this and treated accordingly if necessary. The action of this method, of course, is by the drug penetrating by osmotic action right through the gum, periosteum, and bone to the nerve trunk at the apex, which is, as a rule, completely anæsthetised, thereby rendering the pulp, and therefore the dentine, insensitive.

There is one other method of using cocaine that has been adopted for anæsthetising the six upper anterior teeth, and that is by placing a pledget of cotton wool soaked in a solution of about 20 per cent. in the anterior nares. Apart from its extreme uncertainty, it is an unpleasant method, and also, as an American once said, necessitates on the part of the victim the use of a pocket mirror for some time afterwards to reassure himself of the presence of his nose.

And now, secondly, to speak of the method of treatment for a later or remote effect. Some of the drugs that one has already mentioned may be used, such as, for instance, carbolic acid or oil of cloves. Either of these may be sealed in the cavity for a few days with gutta-percha or oxysulphate of zinc. Carbolic acid must not be used if too close to the pulp, on account of its irritating properties. Arsenious oxide has been used in a similar way in quite shallow cavities, and, although generally successful, there is a grave risk of inflaming, if not killing, the pulp, as its action has no limitation short of destruction of the pulp.

There is a drug which has been more recently introduced for this purpose, and that is paraform. This is a solid product of formaldehyde. This is most advantageously used in the form of a paste, made as follows:—One part of paraform is mixed with ten parts of zinc oxide, and then made into a paste with a mixture of carbolic acid and menthol in equal parts. A very small quantity of this is introduced into the cavity on cotton wool, and then wiped dry with a clean piece of wool, so as to leave only a very thin film over the surface of the dentine. Gutta-percha or cement is then introduced to seal the same, according to the nature of the cavity. Another and convenient method of using paraform is to mix it, in similar proportions to above, with the powder of Fletcher's artificial dentine (oxysulphate of zinc), and then to fill the cavity with this mixed in the ordinary way. Either of these mixtures is left in for a few days, but may be left for a week or two, if only a superficial cavity, and seemingly with advantage. The action is a little doubtful, but it apparently cauterises the ends of the dentinal fibrils, but, having good penetrating powers, seems to act more deeply than most other drugs upon the dentine.

The oxyphosphate cements, and still more the oxychlorides, both have good effect in allaying the sensitiveness of the dentine, although the latter is more likely to give rise to pain and possibly to inflammation of pulp if at all near the same. They act by the free phosphoric acid in the one, and the zinc chloride in the other, cauterising the dentinal fibrils. Their disadvantages are that they have to be left in for several weeks, and then necessitate the use of the engine for grinding them out again.

In spite of all these methods of treatment, there are some patients on whom nothing seems of any avail. This may be due to extremely sensitive tissues, in an otherwise more or less normal person, but is rather more often due to an unfortunate neurasthenic condition of the patient, who, for their own ends (as they think), will wilfully mislead one as to their feelings. The only treatment in this case—and even then it is very difficult to proceed—is to temper your gentleness and consideration, which must never be relaxed, with a considerable degree of firmness. From that, of course, it is plain that it is very important to fully recognise the condition. Otherwise, one may jump to a conclusion of neurasthenia a little too soon, and the

treatment of firmness may be misapplied. One can generally make a correct diagnosis by varying the site of operating movements from moment to moment, by placing the excavator or burr upon the surface of the enamel, or a blunt instrument upon the healthy gum. In either of which cases, if the patient shows apparent evidence of pain, one knows the condition to be one of neurasthenia, with not necessarily hyperæsthesia of the tissues, and the patient must be given to understand that one knows exactly when he or she is feeling any real pain. But never for a moment lose your temper with these trying patients, or the condition will only be aggravated.

One other point. Patients' tissues are often much more sensitive when they are "run down" in health or are recovering from some illness. Under such circumstances much may be done by putting in temporary fillings and making another attempt after a few days, or longer, when the patient is more robust.

That also reminds one to say that all cavities that are not going to be filled at once should, if possible, have temporary fillings introduced, if they are likely to be sensitive. For the longer a cavity is subjected to the irritating influences from the mouth, frequently the more sensitive does it become.

Reviews, etc.

The price of books submitted for review should in every case be stated.

Manual of Ophthalmic Surgery and Medicine. By Walter H. H. Jessop, F.R.C.S. Second edition. (Messrs. Churchill.) Price 9s. 6d.

In the second edition of this useful text-book, the first has been revised and in great part re-written. The size of the book has been increased to 531 pages, and the illustrations to 155.

An interesting feature of the book is the reproduction, for the first time in England, of photographs of the fundus oculi, taken by Professor Dimmer of Graz. Some of these are very good, and will be fully appreciated by the skilled ophthalmic surgeon; we think, however, that the inexperienced student would learn more from a good coloured plate—*e.g.*, compare the photograph of the cupping of the optic disc in glaucoma (Plate II.) with the coloured plate of the same (Plate VII.). The coloured plates (Plate III.) are rather poor.

In the preface the author rightly emphasizes the importance of asepsis in ophthalmic practice; but he forgets this excellent principle, in recommending (page 469) the use of "an eye cup," or "a small indiarubber ball syringe" for the application of lotions to the eye.

It is very important to diagnose follicular conjunctivitis from trachoma early in the course of each disease; but the differential diagnosis, given on page 60, is of little value to the student. We think that the use of jequiritol in "dry trachoma" (page 68) is to be avoided, but it gives excellent results when acute pannus is present. No mention is made of the treatment of trachoma by X-rays.

We agree with the author that "simple extraction" of cataract is the best, and we regret he has not told us when it is "absolutely necessary" (page 259) to do an iridectomy.

On page 487 it is stated that Calmette's ophthalmo-tuberculin test "seems to be quite harmless." This was the more or less general experience in the early days of the test, but recently several observers have found it otherwise, and keratitis, ulceration, and even sloughing of the cornea, have followed its use.

The description of Mackenzie-Davidson's method of localising a foreign body in the globe (page 502) is far from clear. "To some spot on the lower eyelid that bears a known relation to a recognizable point of the cornea, a small piece of lead wire is fixed by strapping." The piece of lead wire is fixed to the lower lid usually in the middle line, and the relation of the top point of the wire to the centre of the cornea is accurately measured (calculation 1). It is not necessary to "mark the situation of the cross wires on the patient's face by Indian ink." The foreign body is localised in relation to the plane of the sensitive plate and to the planes, which pass through the cross wires at right angles to the plate (calculation 2). The point of the lead wire, fixed to the lower lid, is localised in a similar way (calculation 3); so the relation of the foreign body to the point of the wire is ascertained (calculation 4). Now, as we have already ascertained the relation of the point of the wire to the centre of the cornea, we can readily find the relation of the foreign body to the centre of the cornea.

The book is well printed, easy to read, and the illustrations on the whole are good. It should maintain a worthy position among the many text-books of a similar nature.

The Sexual Disabilities of Man and their Treatment. By Arthur Cooper, M.R.C.S. (H. K. Lewis.) 4s. net.

This little book contains a considerable amount of information upon subjects which are little discussed in medical schools. It gives a clear account of the different forms of sexual disability in man, and attempts to indicate the treatment suitable to each. It is in two parts, dealing first with Sterility, secondly with Impotence. The chapters upon treatment are sure to prove valuable to practitioners. The author insists that the male is responsible for a childless marriage much more frequently than is now recognised.

Periodicals received.—The Hospital; The Clinical Journal; Manchester University Magazine; Le Mois Médico-Chirurgical; The Prescriber; Broadway.

Notes of a Roving Guy's Man.*

IX.

GRAZ is the capital of Steiermark, the Austrian principality that adjoins Saltz-Kammergut and Tirol on the one side, and the mountainous southern provinces on the other. It is a town of some 150,000 inhabitants, with a fine university, five large hospitals, and a reputation that is certainly well deserved. In Berlin one heard of Graz and its fame in the surgical world. Every surgical student has heard (or ought to have heard) of Nicoladoni—the man who "made a new thumb out of a toe," and whose services to orthopædics are certainly not less important than his contributions to general surgery. Nicoladoni, alas, is dead, but there are other good men at Graz. Professor von Hacker, whose work in intestinal surgery is so well known; Professor Langer, who is an authority of diseases of children; and Dr. Spitzy, who is one of the pioneers of modern nerve surgery, and whose important contributions to orthopædics, made during the time when he was Professor Hoffa's right-hand man, are equally well known. One looked forward to Graz, but after the disappointment of Vienna one was quite prepared to find it much less important a place than it was said to be. Still, a week or two would not matter, and there were always mountains to climb if clinical material did not come up to expectations.

Such initial doubts were entirely unnecessary. Graz is one of the finest Continental centres, clinically as well as in other respects. The town itself is picturesque, and delights in an environment that few other cities can rival. Through it flows the fine river Mur, roaring and noisy, for its bed is uneven and steep, and in the centre, like a gigantic watchman guarding the red house-tops, stands the 800ft. high "Schlossberg" in a wealth of pines, oaks and chestnuts. In the distance are the Styrian mountains, snow-capped and clothed with their pine forests, easy ascents for the most part, though wider afield there are peaks which the most practised Alpine climber need not sneer at. If it cannot compare with Salzburg for wildly romantic beauty, or with Prague for old-world picturesqueness, Graz can yet pride itself on possessing a beauty and charm of its own which rapidly win the admiration of the stranger. Its old streets are full of quaint bits, interesting fragments of architecture, loggia, architrave, clerestory and freize; every corner reveals a "paintable point," and the old public buildings are not the least worthy of close inspection. In the Landesmuseum is a small but excellent collection of pictures and prints, among the latter being an admirable and almost complete set of Chodwiekies, many of which are of medico-historical interest. From the student's point of view it is a little Paradise. Lodging and living are cheap and good, the inhabitants are a constant source of interest for the man who delights to study such things as manners and customs, and the hospitals are undoubtedly worthy to rank as among the best in Austria. To the graduate student who wishes to do real practical work, Graz is a veritable mine of good things, and he would be a fool who preferred Vienna, with its overcrowding, its expense, and its limitations.

At the Anna Children's Hospital, a large block situate near the fine park, and in some respects one of the best children's hospitals in Austria, I found Dr. Spitzy with his two chief assistants, Drs. Hornung and Meyersbach, in charge of the surgical and orthopædic division. The work here proved so interesting that I found it impossible to stick to my original plan, but decided to make Graz my headquarters for a couple of months at least. Even in that time one has scarcely a possibility of seeing everything and noting down all that is of interest. Dr. Spitzy himself is comparatively a young man, a fluent linguist, speaking English, French and Italian, and contributing original articles from time to time to professional papers in America, Italy and France; a man who has refused a professorship at a large American university because he is sincerely attached to his native land, a fine teacher, able to put his subject clearly and tersely, one of the most expert operators I have yet had the pleasure of meeting, original and daring, as well as thorough and quick, and, personally, like Lorenz, one of the most charming and companionable of men. One may be pardoned for "enthusing," but to me it has been a positive pleasure, after months spent with the hard "German school," where the patient is an interesting case more than a sensitive human being, to watch the sympathetic manner in which he treats his little patients. Going the rounds in the wards of the Anna Children's Hospital is not the hulla-baloo it is in some children's hospitals; the kids cluster round and smile, and when a bad dressing has to be done they undergo their little martyrdoms with exemplary stoicism, solaced by a "*Sei brav*" or two. They know a great deal about themselves, these kids, and will toddle up to you, as soon as they have become acquainted with a new face, and explain what is the matter. "I've got an upper arm fracture," I was told by a small boy, "and it's being treated with suspension extension," showing the lump of lead which he carried in his hand, and grinning a smile of self-satisfaction. The wards are small, but scrupulously clean, and with more than sufficient air and light space, and there is a large balcony which is in use daily. Operations start at half-past eight in the morning, and are usually over by eleven: then new patients are seen, the ward round is done, and by midday the morning's work is finished. Out-patients, which one of the chief assistants takes, come in the afternoon. On the first floor is the medical division in charge of Professor Langer. Here were some interesting cases, a Raynaud, a case of multiple epulis (? gingivitis hypertrophica), a pneumothorax, and several hydrocephalic cases. On my first visit, owing to the "student's strike," no lectures or demonstrations were given, but the Professor went round as usual, while in the surgical department the strike made no difference whatever in the daily

* Series I., II., III., IV., V., VI. VII., and VIII. of Notes appeared in GAZETTE of April 4th, May 2nd, May 16th, June 13th, August 8th, August 22nd, September 5th, and October 3rd.

routine. Dr. Spitzy was good enough to invite me to attend every afternoon at his house where he has his private clinic, and as this gave me an opportunity of seeing many interesting cases, I gladly availed myself of the invitation. The private clinic is admirably arranged, and larger than that of Professor Joachimsthal. The gymnastic and crawl room, fitted up with all necessary apparatus, is daily occupied by a squad of little patients. Behind this is the X-ray room, while on the other side again are the plaster room and the consulting rooms. On the upper floors are the private wards for operation cases and the living rooms. On the basement is the model room, with the necessary workshops.

At the Children's Hospital a large variety of cases can be seen, not all orthopædic. Hernias, for example, are very frequent. The usual operation is Kocher's second or third method, and the anæsthetic given is ether, by the American open method. The anæsthesia is very light, and the operation is very quickly done. Thus, I have seen Dr. Spitzy do four hernias within half an hour, this including suturing and dressing as well—an average of just under eight minutes for each, without allowing for the waiting interval! The real operation itself he does in four minutes in uncomplicated cases. This rapidity is possible when the invagination method is used and wire sutures are employed, but even then it means much practice and a great deal of experience. My own time, with the doctor himself dressing, averaged ten minutes—a result of which one may be proud enough when one considers that twenty minutes or more is the average at Guy's! It must be borne in mind that this means the whole time—from the incision to the removal of the patient from the table, ready for taking back to the ward. Gloves are worn, and the operation site is sterilised in the usual manner, finally with iodine tincture, and then brushed over with "*Klebestoff*." The after-treatment is as with us. The child is put on a special frame which renders soiling of the dressings practically impossible. Stitches are removed as soon as possible, and the healing is rapid and uneventful. The operation as done here is certainly an improvement on what I have seen elsewhere. All hernias, inguinal and umbilical, are advised operation, and the permanent results certainly justify this treatment, which is so different from what our authorities, such as Mr. Macready, advise. Recurrences in inguinal cases done by the Kocher method have not been observed, though the time spent in hospital is far less than with us, and in no case is a prophylactic truss or supporting bandage allowed when the child is sent home. In umbilical cases, rectoplasty is done, silk sutures being invariably used. Equally rapid are the other operations, the nerve suturing and tenoplasty. Dr. Spitzy holds, rightly, that with children especially rapid operating is absolutely necessary. It obviates the long anæsthetic, which is not without its dangers, and makes operation possible in very lightly anæsthetised patients. At first I had some doubts as to the wisdom of such rapid operating on half-conscious children, but after six weeks' experience of these cases, I have come to consider that the method is sound on the whole. In a few cases local anæsthesia is used, as in operating on a child with pyopneumothorax. The patient, a little girl of eight, bore the operation very well, only feeling it when the finger was thrust into the cavity. Here, again, experience in injecting the cocaine solution uniformly and penetrating deeply on to the rib periosteum contributed to the success. Of the more interesting cases noted during the time spent here, the following may be cited. Fractures of the surgical neck of the humerus: this is treated with ambulatory extension, as also fractures lower down, as the T-shaped condylar variety. The child carries a weight of lead in his hand, fastened on by plaster strips, and the weight of the arm acts as an extension. In joint fractures stress is laid on early movement and frequent alteration of position. The results, as shown by routine X-ray photographs, are very good. Double fracture of lower jaw in a child by direct violence: this was finally wired with excellent results. Double jaw fractures in children are decidedly rare: in this case the patient had fallen on her chin and the lesion was very marked. Separation of the trochlear epiphysis of lower end of humerus—the third case I have seen of this rare lesion—in a boy of six. Treatment is by extension, with frequent change of position, a good result being obtained. Epiphysiotomy: this is a favourite operation here, and has entirely replaced the older osteotomies. The child is lightly anæsthetised, and a sharp chisel is used. This is entered vertically at the epiphysial line, turned and made to cut through the comparatively soft epiphysial junction. The limb is then put up in a plaster splint in the corrected position. The results are very good, and no bad consequences, such as theoretically would follow the operation (shortening, impaired growth of the diaphysis, &c.), have been experienced. The operation is clean, neat, easy and rapid, with the least crushing of parts, and appears thoroughly rational. "Webbed fingers": this annoying congenital defect is treated both by plastic operation and by Spitzy's bloodless method, the results of which have lately been published by Dr. Hornung. The instrument used is a sharp double knife, screwed down by two racket nuts, which are gradually tightened, thus cutting through the web and causing firm cicatrices, which are not liable to re-unite. The child wears the little instrument day and night, and appears to find it no great inconvenience. Necessarily the method has its limits and demands close supervision, but it is certainly a modification which deserves trial in many cases. The visitor at the Children's Hospital is at first struck with the number of small patients with crushed and badly-torn fingers, and really Graz is in the unenviable position of yielding the most material for a study of traumatic lesions of the hands in juveniles. The reason is very simple. The Styrians patronise a patent "chaff cutter," which has earned for itself the nickname of "finger machine." This fatal piece of machinery is a source of constant admiration and delight to the juvenile community, the members of which, fired

with an Empedoclean curiosity to investigate

"The moving wonder, this most mystic wheel,
Moved by some God or Demon to what end?"

promptly rummage its interior with such disastrous consequences to their fingers. It would be the simplest thing in the world to prevent such mishaps by adopting a wire screen guard, but that is an innovation which the Styrian farmer does not like. So every month the Finger Machine sends its quota of victims, and the assistants at the hospital have the most unique opportunities of studying "the conservative surgery of the hand." Usually the cases do very well, under a simple dressing of Peruvian balsam; in a few gangrene and secondary amputation follow.

The most interesting cases at the clinic are undoubtedly those of nerve lesions and the treatment of deformities due to paralysis. As I stated in my former letters, the results of nerve and tendon transplantation which I have seen in England and at the German clinics have not impressed me favourably with the usefulness of the methods. I therefore approached Dr. Spitzy's cases with a certain degree of natural suspicion, and perhaps undue caution, not to say prejudice, and only the brilliant results which he has obtained have turned the scoffer into a firm believer. As is the usual case with converts, my enthusiasm may drive me to overestimate the value of the results, but I will try to put the case for neuroplasty as baldly as possible, and leave the reader to form his own conclusions. Here, as elsewhere, constant practice and great experience, together with a nice discrimination and selection, are largely responsible for the results. The child to be operated upon is carefully examined, and the operation as carefully considered before it is proceeded with. The essentials of the operation are interesting. Spitzy lays bare the nerve and operates with astonishing quickness, and the consequent exposure is by no means prolonged. Care is taken not to handle the nerve, nor to tease it with forceps or instruments. For holding it, the operator uses his own nerve forceps, which are blunt, curved instruments, usually ringed with ivory. The anastomosis is by implantation. To quote Dr. Spitzy himself: "I have found the best results by implanting the end of the non-functioning nerve into a longitudinal slit made into the functioning nerve. The anastomosis must be fixed with a longitudinal suture, since a transverse suture, owing to the extraordinary sensitiveness of the nerve substance to pressure, destroys its conductivity and may lead to degeneration. With longitudinal slits in the intact nerve and longitudinal suture the damage is not great, as can be demonstrated by histological preparations. Only when it is technically impossible to have the cut and suture parallel to the fibres of the functioning nerve, a few fibres are cut transversely, and therefore degenerate. The more perfect the cut and suture are, the less is the ultimate damage." (*Zur allgemeinen Technik der Nervenplastik*, p. 5.) He lays great stress on perfect adaptation. Where possible the suture is paraneurotic, but if this does not secure coaptation he does not hesitate to pass his suture directly through the nerve substance. To immobilise and secure still further this coaptation he adopts Foramitti's proposal to employ dogs' arteries hardened in formalin (*Contributo alla Chirurgia Nervosa*, 1908, p. 11). Such arteries are thin, translucent elastic tubes, which are cut in their long axis and then carefully sewn round the suture junction. This is undoubtedly an excellent aid, as it clothes the junction point with an impermeable organic sheath which really strengthens it, much more so than a bit of torn omentum used as a graft in an intestinal anastomosis. Seeing his cases and results one is convinced that, to a large extent, his success is due to the excellent technique he employs. The direct implantation method, for instance, is a great improvement on Letiévant's flap method or Powers' modification, just as the arterial sheath is an improvement upon Gluck's decalcified bone tube. Interposition methods, such as tried by Heath and Damer Harrison with us, and Peterson and Powers in America, are of very little use: where they succeed they owe their success to a very vigorous *regenerative power in the non-functioning nerve*. That the end-to-end method gives good results is undoubtedly true. Thus Mr. Ballance, I believe, sutures the proximal end of the hypoglossal end-to-end to the facial, and then the distal end to the proximal end of the cut gustatory, with very good results. Spitzy implants the facial into a longitudinal slit in the hypoglossal, a method which has its obvious advantage.

So much, briefly, for the technique. Coming to the results one is struck by the uniformity of success that has been obtained. In Spitzy's hands neuroplasty is no longer a chance operation like the Talma-Morison. It is an exact surgical procedure which no more depends on chance than the usual legitimate surgical operations do. Chance, indeed, is a factor which every surgeon has to weigh—one has only to read Pirogoff's classical essay on "Luck in Surgery," to recognise that. But there is a stage when it is reasonable to expect that luck will be on the side of good methods; God, on the side of the best operator. Nor in estimating results must one lose sight of the fact that nowadays a great many neuro- and tenoplasties are made indiscriminately. The operator transplants this or that nerve or tendon and proudly claims that the resulting benefit is to be ascribed to his operation, whereas it is really due to the massage and accessory treatment. It is of course possible to go to the other extreme and refuse to recognise the undoubted value of such transplantations. To judge a case, especially where a paralytic deformity is concerned, one has not only to ask oneself, "Would this case have shown an equally good result were it treated orthopædically by conservative methods?" but more, "Has the operation benefited the patient more than persevering conservative treatment would have done?" Neuroplasty and tenoplasty must stand or fall on the answer to the latter question. There can be no question of a "just-as-good method." Unless these new methods are *better* than the old they need not be considered, for in that case their indications would be few and far between.

Approaching Dr. Spitzy's cases in this rather hypercritical spirit, one must acknowledge that they, at least, eminently prove that the operations were justifiable. And here I cannot refrain from pointing out how fairly and frankly Spitzy presents his cases. One can see his failures alongside his successes. The failures have been the attempts to innervate the anterior crural (for quadriceps paralysis) by anastomosis with the superficial branch of the obturator. In four cases the patients have so far shown no decided improvement, although the vasti have regained a certain amount of power. This failure is probably due to the fact that the superficial branch of the obturator is much too small, and contains far too few axis cylinders to innervate so large a stem as the anterior crural. A similar failure has attended Van den Bergh's attempt to anastomose the anterior crural with the great sciatic. On the other hand, the results in cases of paralysis of the nervus peroneus, by implanting this nerve into the posterior tibial, have been excellent, and in all these cases the good results can really be ascribed to the operation and not to any accessory treatment, the latter having been systematically tried before the anastomosis was made. Equally brilliant are the results with upper limb nerves, and I am indebted to Dr. Spitzy's courtesy for a knowledge of the following cases which excellently illustrate these results. One is a boy who, in consequence of an upper arm fracture, was paralysed in extensors and supinators of forearm and abductors of thumb since birth. Twelve years later Dr. Spitzy anastomosed the peripheral end of the non-functioning musculo-spiral longitudinally into the median. Two months later the power of extension and supination had returned, and at present, three years after the operation, the boy is able to use his formerly paralysed hand as well as his sound one, playing the piano, steering a bicycle, etc. The other cases are even more interesting, as they concern a condition in which Spitzy's operative work has been pioneering — Little's disease. There are two things which strike the English student specially at the German hospitals, the prevalence of coxa vara and the equally large number of cases of spastic paralysis. Of the frequency of coxa vara I have already written; of Little's disease, I have seen more cases here in a week than I have been able to observe during my whole term at Guy's. At Shadwell, during nine months' attendance at Out-patients, I saw only three cases; at Guy's, perhaps eight. How frequent the condition is in Germany may be seen from the fact that Fränkel and Glaessner were able to collect no less than 106 cases of Little's disease and spastic hemiplegia during one year at the Berlin clinic. There are few diseases that are so interesting, both from an orthopædic and from a purely neurological point of view, and the pathology of Little's disease is so obscure, and the treatment so unsatisfactory, that any light upon it must be welcome. Fränkel's work is an able contribution to the literature, and Förster's recent theory is equally interesting. As the latter may be novel to some readers, I may briefly outline it here, as a knowledge of its main points throws light on the recent operative treatment. What is the cause of spastic contracture? When one takes up a recent work on neurology, such as Bechterew's or Oppenheim's text-books, one sinks at once into a slough of theories, all more or less far-fetched. That spasticity depends on patches of sclerosis "irritating" the anterior horn cells is quite unproved, and against the theory that it depends on degeneration of the inhibitory fibres in the pyramidal tracts is the insuperable objection that experimental destruction of the lateral tracts, as Van Gehuchten has shown in one of the most interesting and readable of classical papers, does not cause spasticity. That it may be due to peripheral irritation is acknowledged. Brissaud's case of aneurysm of the basilar artery which caused spastic facial contracture, and the recorded cases of trismus following a tubercular nodule at the trigeminal nucleus, are cases in point. All the rest is pure assumption, if we exclude Jackson's theory. This is supported by the clinical evidence that lesions of the pons or peduncles lead to early spastic contractures. Förster, in his recent work (*Die Kontrakturen bei den Erkrankungen der Pyramidenbahnen*), has tried to criticise Mann and Monakow's views in the light of his clinical experiences, and has found that, primarily, spastic contractures are postural contractions. With a hemiplegic patient, it is the easiest thing in the world to obtain any variety of contracture one wishes; the main factor is that the insertion point of the group of muscles which it is desired to contract must be approximated. In some cases (as in flexibilitas cerea, catalepsy, and extreme grades of paralysis agitans), it is sufficient that this approximation should be momentary. With a hemiplegic it must be of much longer duration. The so-called characteristic contracture of the hemiplegic patient is due entirely to the position the patient occupies in bed. Forcibly extend his thigh and keep it extended for a day and he will assume a spastic extension contracture when the extending force is removed. Similarly, in the case of a child with Little's disease, the "characteristic" positions of the hands and feet are due to the same cause; the muscles have merely contracted in a position of intra-uterine rest, that is, in the position in which, through the "lie" of the fœtus in utero, their insertion points were approximated. Van Gehuchten's apes, with their pyramidal tract destroyed, dragged themselves about and got no spastic contracture; when confined in a cage, with the paralysed limb in a peculiar position, a contracture at once established itself. Förster adduces numerous examples, culled from a large clinical experience, and appears to have founded his theory on more than mere assumption. At any rate it is a theory that appeals to the orthopædist, for it points out a hopeful chance of treating a case of spastic deformity. Briefly put, the line of treatment is, "strengthen the cortico-motor neurons, and try to restrain the activity of the peripheral neurons." This is the principle on which the new operation, division of the posterior root ganglia, is founded, and this, too, has led Dr. Spitzy to attempt neuroplasty in certain selected

cases. The object in this is to attempt to prevent the peripheral irritation by suitable treatment, and by over-correction, to de-approximate (if one may use the word) the insertion points of the contracted muscles. By carefully considered, methodically carried out "stepping" exercises, aided by over-correction and fixation, and a preliminary adductor tenotomy, these patients to a large extent regain power and control over the lower limbs. Thus I have seen, at Dr. Spitzy's private clinic, a young man who has perseveringly followed this treatment for many years, and is now more or less independent, able to go about comfortably, to dress himself without help of his valet, and to cross the street without making himself conspicuous by his contortions. But the matter is not so easy with the upper limbs. Tenotomy, mere de-approximation, is not sufficient here. It is necessary, to quote Dr. Spitzy once more, "to transplant the superfluous energy of a group of muscles into the weaker antagonising group." On this principle is founded the operation which has now been so successfully carried out in many cases. The typical position of the hand in a case of Little's disease is a position of palmar flexion, the fingers spastically contracted in extreme flexion, the forearm pronated, the thumbs adducted. For the extreme pronation Hoffa had already tried his pronator-plasty, with tendon transplantation of the ulnar flexor. It needs only a glance at such a "typical hand" to see that the condition is practically on all fours with a musculo-spiral paralysis; only here the median innervation overpowers the musculo-spiral groups, and the condition is one of relative hypertonus of the flexor group as opposed to relative hypotonus of the extensor-supinator group. The whole question now is, Can median nerve plasty strengthen the latter group of muscles? in other words, is it possible to switch off a part of the innervating force from the median nerve directly into the nerve bundles of the musculo-spiral? In order to test this question the first operations were undertaken, and they have been so brilliantly successful that they deserve to be tried in all suitable cases in future.

The first patient operated upon was a girl of three and a half years with typical claw-hand, and lower limb contractures. The usual plaster splint was given after an achillotomy by Beyer's method. Then a part of the median nerve was centrally implanted into the stem of the musculo-spiral, the usual technique before described being followed. The arm was encased in a plaster bandage in over-correction. Three weeks later the bandage was removed and passive movement with galvanic stimulation commenced. Two months later the result was astonishingly satisfactory. The child could flex and extend the hand and fingers easily, pronation and supination and thumb movements were normal. Five months later all the movements were normal, though they were made slowly. The child could "make a fist," and could compress its nose between index finger and thumb. At present the condition is equally satisfactory, and the only abnormality to be noticed is that the flexion of the terminal phalanges is not quite perfect. Another patient is a child, operated upon when twelve years old. She had a splastic hemiplegia of the right side, and could not extend her fingers, supinate her forearm, nor abduct her right thumb. A third of the median was centrally transplanted into the musculo-spiral. At present, not quite a year after the operation, she can extend the fingers, abduct the thumb, and easily supinate the forearm. Yet a third case was a boy of ten with an almost similar condition on the left side. Here, too, part of the nervus medianus was implanted into the nervus radialis with equally good results, and the movements are almost entirely normal, though the operation was only done some nine months ago.

All these results are of great interest and of as great importance. They show that Dr. Spitzy is right in his conclusions that it is possible to transmit part of the innervating force from one group of muscles into an antagonising group. What is more, all these neuroplasty operations prove that our knowledge of the regeneration of nerves is still very far from being complete. When one considers, for instance, that a nerve which has been functionless for twelve years is restored, so far as its function is concerned, within a few months, one begins to have doubts as to the truth of the usually accepted theory of nerve regeneration. Nervous tissue does not grow very rapidly, and it seems scarcely possible that within so short a period an axis cylinder can sprout a distance of several inches from the proximal end right down to the periphery. It seems much more reasonable to accept the more recent views that growth in a nerve may proceed from both ends, and to ascribe some value in the return of function to the presumably wholly degenerated distal stem. The whole subject awaits further research, particularly in such successful cases of neuroplasty. Meantime, Dr. Spitzy does not trouble himself about what the physiologists say. He is satisfied with his clinical results, and so, too, will be anyone who has had the opportunity of seeing them.

Equally interesting and equally excellent are the results obtained by judicious tenoplasty. The cases are selected and carefully treated by massage and electric stimulation after the operation. Needless to say, a tenoplasty is not done where conservative treatment holds out a chance of improvement, and the orthopædic treatment, both at the Children's Hospital and at the private clinic, is so thorough that the cases subjected to tenoplasty are really desperate cases. The success which has attended these attempts is therefore all the more striking, especially in bad examples of infantile paralysis and foot deformities. In a few cases tenoplasty was done for peculiar conditions. An interesting case was that of a gentleman with double dislocation of the long extensors of the thumb, rendering extension of the second phalanx impossible unless passively assisted The thumbs were in a position of adduction with strong palmar flexion of the second phalanx, a condition which seriously interfered with the patient's occupation as a musician, as he found himself unable to use his thumb

properly while playing the piano, the strong flexion limiting his reach to practically one octave. On examination the tendon of the M. extensor pollicis longus could be readily felt, not in its normal relation to the base of the first phalanx, but dislocated towards the ulnar side into the hollow between the dorsal part of the index and thumb metacarpal. It could be replaced in its normal position, and while held there the patient could extend his thumb completely, but as soon as this passive assistance was left off, the tendon slipped back out of its groove, and complete extension again became impossible. In a similar case Dr. Spitzy has modified Haberer's operation, in which a new canal is formed for the dislocated tendon by a tunnel manufactured out of a fibro-periosteal flap from the metacarpal, by suturing the long to the short extensor and replacing both in their original grooves, strengthened by a fibrous bridge after Haberer's method. This method has given very satisfactory results. The operation is done under local anæsthesia, and as soon as it is completed the patient can extend his thumb. A fixation bandage is applied, and eight days later the stitches are removed and active and passive movements commenced to obviate any adhesions between tendons and tendon sheaths.

Perhaps the most interesting operation, apart from the purely nervous work, one sees at Spitzy's clinic is his osteotomy of the upper end of the humerus for the correction of certain shoulder and upper arm defects. The best illustration of this novel method will be a brief description of the two cases which were done lately, and which I was able to observe carefully as to the immediate result. The first was the case of an intelligent little girl with incomplete Erb's paralysis. The supra-scapular nerve was affected, the paralysed group being the outward rotators, the spinati and the teres minor. The result was a complete inability actively to rotate the shoulder outwards, to touch the side of the face with the finger tips, or to perform any of the movements which are requisite for such a combination as obtains in "military saluting." The involvement of the teres minor pointed to some degeneration in the circumflex, but had very little to do with this loss of abducting power, since the main abductors are the spinati. The first thing here was to attempt a nerve plasty. At the operation, however, this was found to be impossible, the supra-scapular being involved in a mass of fibrous tissue and itself reduced to a mere fibrous remnant. Central implantation offered no hope of success here, and the supra-spinous wound was accordingly closed, and an incision was made on the outer side of the upper arm. The humerus shaft was exposed and chiselled through below the deltoid insertion. The lower fragment was then strongly rotated outwards, and accurately approximated to the upper fragment in this position. The arm was put up abducted to a right angle with the shoulder, in strong outward rotation, with flexion of the elbow-joint, and immobilised in an accurately-fitting plaster bandage. Passive movement was begun early, for the patient made a rapid recovery, the wounds healing by primary union. At present the child's condition is eminently satisfactory. The arm hangs comfortably by the side, and there is a strong mass of callus to be felt at the line of section of the bone. The palm of the hand looks forwards and outwards, owing to the strong external rotation which the shaft of the humerus has undergone, and in which it has firmly united, but except for this it would be difficult for an observer unacquainted with the case to say what has been the matter with the child. She can now salute as smartly as any cadet, rub her face, or do her back hair (a proceeding which is not yet an absolute necessity in her case), although there is still some stiffness in these movements. To all intents and purposes abduction and external rotation at the shoulder-joint are normal, but this is, of course, by no means the case, as the muscles concerned in these movements are still paralysed. What has been done is that the arm has been passively rotated outwards, and the deltoid now acts, together with the biceps, much more strongly as an abductor. The slight limitation of pure adduction is gradually passing away, and it is quite evident that in the course of a few months the movements at the shoulder-joint will be practically normal. The second case was that of a boy of ten with complete ankylosis of the left shoulder-joint, probably the result of old tuberculous disease. When I saw him at Out-patients the limb was in a typical position, abduction limited to a third of a right angle, all shoulder movements equally restricted; no pain or tenderness. The treatment with us would be resection; at Vienna, forcible breaking down of adhesions would probably be considered as well. Both have their obvious dangers, chief of which is that such interference at the site of old disease may light up the old focus, and once more give rise to grave trouble. That this is no mere text-book statement, founded on one or two rare cases, such as rupture of an aortic aneurysm by passing an œsophageal bougie, pulmonary embolism by too vigorously handling a parenchymatous thyroid tumour, or purulent meningitis following perforation of a retro-pharyngeal meningocele in scraping for adenoids (all of which have occurred and may again occur!) is shown by quite a number of cases. Of such I have seen three during the last six months, one of which is the kind of case one is not likely to forget in a hurry—rapidly fatal miliary tuberculosis set up by "forcibly correcting" an old tuberculous hip ankylosis. In this case, too, Dr. Spitzy decided upon an osteotomy. The humerus was exposed, divided high up, near the surgical neck, but entirely outside the joint, the arm abducted and put up in plaster. The principle of the operation is easy to understand, for it is comparatively simple, and the wonder is that no one has hit on it before! What is required is that the arm should be raised; gravity, its own weight and backward rotation of the scapula, will suffice to depress it. In this case the lower fragment is joined to the upper at an oblique angle, and the arm is practically ankylosed in a position of extreme abduction. The two fragments have joined well, and the boy is daily

improving, though it is as yet too early to judge the final result. The operation is an innovation which appears likely to become of value in orthopædic surgery, and one can only hope that Dr. Spitzy will publish the results of these cases with full details, in the near future, so as to bring his method to the knowledge of surgeons generally.

There are a great many other features of interest in the work at this clinic, and almost every day one sees good cases which are out of the way or present difficulties. One case was, at first sight, very puzzling. This was a little girl with a pecular limping gait, quite different from anything I have yet seen. There was no obvious hip lesion, Trendelenburg's sign was negative; it certainly was not coxa vara, therefore, or congenital dislocation. Old tuberculous disease one would almost exclude, the child looked so healthy and well, movements were so free, and, in fact, the only sign one could discover was slight shortening of the left leg and a marked depression of the left pubic bone when compared with the right. In nine cases out of ten, I suppose, the diagnosis on the present condition alone would have been well-healed old coxitis, with the odds in favour of the pneumococcal or influenzal type. The history, however, at once cleared up the case. The girl had sustained a double pelvic fracture, three years ago, followed by necrosis, and the sequestrum had been removed through a vaginal incision, thus leaving no scar. The line of fracture, as the old skiagram showed very clearly, had involved the acetabulum on the left side, but healing had been so perfect, considering the severity of the lesion, that the function of the joint was almost unimpaired. The importance of the case at present lies in the possibility of future obstetrical difficulties, as the pelvis is probably narrowed.

Another good result was a case of epispadias in a little girl, treated by the plastic method with excellent success. Such cases are by no means easy to cure, and the after-treatment is laborious and difficult; in the majority a condition of obstinate incontinence follows, owing to prolapse of the urethral mucosa. Rectal prolapses in children are invariably treated by injections of parafin—not, as at Berlin, by the silver-wire method. The injections have been very successful, and the late assistant at the clinic, Dr. Kephallinos, has published the results of a series of cases so treated, which show that recurrences are practically unknown. Great stress is laid on not puncturing the rectum itself, the injection is not made, as Mr. Burgess advises, into the sub-mucosa of the prolapse itself, but into the pararectal tissue—a proceeding which prevents any risk of sepsis. An ordinary injection syringe of large calibre is used, and two injections of 5 c.c. each usually suffice. Before the injection is made the prolapse is completely reduced. Embolism and abscess formation have not been recorded.

At the private clinic a large number of interesting orthopædic cases are seen. As at Joachimsthal's clinic, celluloid is almost exclusively used, and for private practice it certainly has great advantages over plaster or leather. The preparation of celluloid "insets" for flat feet, genu valgum, etc., is very similar to that which obtains at Berlin, but in each case the patient is very carefully fitted, and close personal supervision is exercised. In the large crawl room gymnastic exercises, and exercises for improving lateral curvature, are daily carried out under charge of a competent instructress.

Want of space prevents me from going more fully into the details of cases of interest and methods to be observed here, but enough has been said to show what the student can learn by coming to Graz and watching the work. At present the place is practically unknown to English graduates who mostly go to Vienna, or flock to Munich, and there are, indeed, no post-graduate courses in the strict sense of the word at Graz. For all that, to those who wish to study quietly, Graz offers many advantages. Dr. Spitzy declares himself quite willing to give post-graduate courses to English students, and the clinical material at his disposal is certainly large and varied enough to make such courses exceedingly valuable and instructive. As I have said, Dr. Spitzy is a fluent English speaker, well acquainted with English and American literature, and even the student whose knowledge of German is rudimentary, will probably find more real benefit from a course of study at Graz than from an equal lengthy stay at Vienna. For myself I can only say that I have found few hospitals so interesting as the Anna Children's Hospital, and few teachers so thorough and excellent as its genial surgical chief.

Graz, August 1908. C. L. L.

Appointments.

Civil.

JUPP, EDGAR NORMAN, L.R.C.P. Lond., M.R.C.S., has been appointed District Medical Officer and Medical Officer to the Workhouse by the Chard (Somerset) Board of Guardians.

SCOTT, T. GRAHAM, L.R.C.P. Lond., M.R.C.S., has been re-appointed Joint House Anæsthetist at the Royal Dental Hospital.

WEBBER, H. W., M.S. Lond., has been appointed Surgeon to the South Devon and East Cornwall Hospital, Plymouth.

From the Gazette's Special Pathologist.

H. L., MANCHESTER.—This growth is a squamous epithelioma, composed of ingrowing epithelial columns invading the muscle layers of the cheek.

Sport.

Rugby Football.

GUY'S HOSPITAL v. LENNOX.

A good crowd gathered for this match at the home ground, on Saturday, October 31st, the stand being especially well filled for an average fixture. The game was a somewhat remarkable one from the fact that, though the hospital pressed continuously—the visitors scarcely crossing the half-way line throughout the second half—they could only score once, and this they would not have managed had not Stringer put on a sprint which, for pure pace, he has seldom excelled. Twice before the close of this latter half Stringer was collared by Garrett coming right across from the other wing, and once Stokes, without a man to pass, and with only the line to fall over, a few yards ahead, missed his pass badly.

Directly the game commenced Guy's scored, Stokes being the try-getter. No goal resulted from Stokes' attempt at conversion, and forward play—strenuous, but rather uninteresting—ensued for a time. At length Garrett, following up very smartly, a favourite and extremely useful habit of this player's, charged Duke's kick down, and, racing on with the ball at his feet, touched down near the posts. Walker failed to add the points from an easy position. Stokes ran in good style before the close of the first half, but Marriott was tackling well, and nothing came of the effort. Marriott also brought Stringer down when running strongly, just before half-time came, with the score standing 3 pts. all.

The hospital forwards quite secured the upper hand after the resumption of play, and heeled out a constant stream of passes, but our halves and "threes" did everything except score. Once Saner and Monaghan got over for a try by the former, but Mr. Devonshire ruled a "knock-on," and ordered a scrum, Then, at last, passing by Saner, Digby, and Lee, and Stringer receiving, raced over by the corner. Stokes made a good but fruitless attempt to goal from the touch-line. Lennox had now settled down to defend, which they did effectually. Our forwards, who, without exception, played well, controlled the situation, but the backs could not penetrate the defence opposed to them, although, as previously mentioned, Stokes, on on one occasion, had a rare opportunity. Lee put in a final effort towards the end, running through almost all the opposing side, but came to grief between Garrett and the corner flag, both of which he grassed in his effort, but ill-luck caused him to lose the ball, which bounced into "touch-in-goal." Nothing further of interest occurring, Guy's won an unsatisfactory game by 6 points (2 tries) to 3 points (1 try). Team :—

GUY'S.—H. L. Duke (back); L. B. Stringer, H. Lee, W. E. S. Digby, L. Stokes (three-quarters); J. G. Saner, P. J. Monaghan (halves); H. R. Mullins, A. H. Crook, H. Hoby, G. Stranach, C. S. L. Roberts, E. L. Elliott, T. D. Stout, G. Seabrook (forwards).

Referee: Mr. Devonshire.

REMARKS.—The pack, although weakened by the absence of Archer, Hind, and Moberley, all played well, and lasted throughout the game much better than the Lennox men. The halves were not good; Saner was apparently out of place at "stand-off," and ran much too obliquely to make anything like decent openings. Lee tried his level best to keep Stringer away from touch-line, but Saner made his task very difficult. Digby was weak. The wing men cannot be expected to score if they are constantly bored into touch. Duke played a greatly improved game.

GUY'S HOSPITAL v. STREATHAM.

Played on the Honor Oak Park ground on Saturday, November 7th, under ideal conditions of turf and weather, before a good number of spectators.

The Hospital were not strongly represented forward, Mullins, Roberts, Williams and Moberley being away; the last named, I regret to say, may not play again till after Xmas, as his damaged knee requires a long rest. Archer was also an absentee, as he was assisting his county down South.

Hind kicked off against the wind, and with Streatham one forward short; play was chiefly confined to the forwards on both sides, and it was early evident that the visitors were going to rely on their feet and not on their hands; they seldom attempted to handle, but kept up a constant attack by means of short dribbling runs, one of which ended successfully after about ten minutes' play, Dickson scoring by the goal posts, for Inde to easily add the extra points. Streatham's eighth forward now arrived, but they only played seven in the pack, keeping a fifth man among the "threes" to grapple with Guy's passing movements; Guy's balanced matters, by pulling Hoby out and making a sort of "rover" of him. The Hospital constantly got the ball, being much stronger in the tight, and Cane sent the ball out frequently, but the passing was not good, and Stokes and Stringer were generally tackled or bundled into touch before they made much progress. The next point of interest was some footwork near the visiting goal line, and Sprague picking up, landed a try, too wide out for Stokes to improve.

At half-time, Streatham led 5 points to 3.

For the major portion of this half, Guy's were in Streatham's "25," and doing everything else but score; true, they were somewhat handicapped by the action of the referee, often ignoring the offside tactics of Treasurer, who was constantly allowed to interfere with Cane in a manner which looked from the stand illegal; still Cane got rid of the ball nicely time after time. Once Stokes sailing down the left wing, should have got clear, but nearing Becker, he kicked feebly into touch, instead of running in determined fashion for the line. On the other wing, a bad pass to Stringer on the part of Jones was unfortunate, Stringer being almost unmarked. At last the Streatham half exhausted even the referee's patience, and was penalised in an easy position for Stokes to add three much-needed points. Just a few minutes before the

end, Stranach broke away strongly, and passing to Stringer, enabled that player, with a very fine run, to ground beneath the bar. Stokes goaled, and the game ended: Guy's, 1 goal, 1 penalty, 1 try. (11 points); Streatham, 1 goal (5 points). Team:—

GUY'S.—H. L. Duke (back); L. B. Stringer, H. Lee, J. P. Jones, L. Stokes (three-quarters); J. G. Saner, L. C. Cane (halves); G. R. Hind, A. H. Crook, H. Hoby, C. G. Sprague, T. D. Stout, H. Stranach, A. Seabrooke, A. N. Other (forwards).

REMARKS.—Considering the fact that Guy's had all the best of the game, they should have scored at least 20 points. There is a weak link in the attack somewhere, either want of pace or resource, and the attacking movements of the wing three-quarters are invariably bottled up before they get into their stride. Stringer's try was a beauty.

GUY'S HOSPITAL v. OXFORD UNIVERSITY.

A record crowd, which included "The Wallabies," assembled at Honor Oak Park last Thursday, to view what must be regarded as the match of the season on the home ground. Conditions were ideal for a fast game, and this we had; indeed, there was scarcely a dull moment from start to finish, and if the home side did not win, they did the next best thing—they put up a great game; they played it through to the bitter end, and there was not a passenger among them. Considering, too, the exertions of Archer and Hind at Blackheath on Wednesday, they are to be congratulated on playing again the next day, and moreover both playing well.

The game had been in progress but a very short time before it was evident that Oxford were out for points; their motto is "Attack" first, last, and always, and if in some of our lesser fixtures more especially, Guy's would adopt the same motto, we are certain they would almost invariably pile up good respectable scores. The Varsity treated us to some very safe handling and heady passing, if one may use the expression, which early resulted in Williamson scoring two tries, one of which Cunningham goaled. Next Cunningham sent Williamson away, who, facing Lacey, passed to Martin, who ran over for Cunningham to convert. Mullins next broke through, but like most forwards, instead of making for the line looked round for somebody to pass to, and missed a good chance; then Stringer came away in fine style, but Gilray brought him down. By this time, half-time was due, and Guy's forwards, who did splendidly throughout, worked the ball down to the Varsity "25," where Lee with a delightful swerve passed Sloan, and amid tremendous cheering gained a try beneath the crossbar. Stokes majorised easily. Half-time, Oxford University 13 points, Guy's 5 points.

The second half was well contested and provided far too many incidents of interest to get into the space available for this report; but quite early Oxford pressed, and to keep them out Guy's literally packed their line with defensive forces; Hoby, and sometimes another forward, were pulled from the scrum to aid the tackling. Vassall made an unsuccessful drop at goal, and then Tarr made a fine run, but Stringer brought him down beautifully; we doubt if either Stringer or Lee have ever tackled so splendidly, One must not forget Lacey also, whose play at full back was safe and certain; he combines neat fielding with good dodging powers, and also kicks accurately. Vassall was next on the move, but Lee accounted for him, and once again Guy's were hard pressed, Tarr ending matters by failing at dropping a goal. Jones, Stringer, and Stokes then came into view with good passing, but nothing came of it; the Oxford forwards dribbled back, when some very fine passing by the Varsity threes got the ball away to Martin, who grounded on the extreme right. Roberts missed the extra points. A good piece of speedy following up by Monaghan so embarrassed Sloan that he kicked into touch at half-way, from where Gilray got going, but Monaghan collared him. A little later Gilray had a fine chance, but was selfish. Stokes, with a great punt, found touch right up the field by the corner flag, and from the line out Hoby had hard luck in not scoring. A mark far out, but in front of goal by Lee, enabled Stokes to have a shot, which just went wide, and a good game ended. Oxford University, 16 points. Guy's Hospital, 5 points. Teams:—

GUY'S.—G. E. W. Lacey (back); L. B. Stringer, H. Lee, J. P. Jones, L. Stokes (three-quarters); J. G. Saner, P. F. Monaghan (halves); H. R. Mullins, G. R. Hind, H. Archer, A. H. Crook, H. Stranach, H. Hoby, C. G. Sprague, A. Seabrooke (forwards).

OXFORD UNIVERSITY.—T. Sloan (back); H. Martin, H. Vassall, F. N. Tarr, C. Gilray (three-quarters); G. Cunningham, R. H. Williamson (halves); H. A. Hodges, L. C. Blencowe, G. D. Roberts, S. Cronjé, J. H. Turner, R. H. M. Hands, R. Honey, J. A. M. Robertson (forwards).

REMARKS.—The forwards were splendid, Lacey very good, and the tackling of the side as a whole was superb. If only a good stand-off half can be discovered to give the three-quarters fair openings, Guy's will be a great side.

Association Football.

GUYS v. EVERSLEIGH.

This match was played at Eversleigh before a fair number of spectators on Saturday, October 31st. Eversleigh won the toss, but this proved of little advantage. After a short time it was clear that the hospital were the better team, the whole side playing much more together than in the last few matches. The three inside forwards for Eversleigh combined well, but found the tackling of our defence very sound, and so were rarely able to get within shooting distance. After about twenty minutes' play, Glover gave Witts a splendid pass, and the latter got clear away and scored. For some time Eversleigh attacked vigorously, and several times tested Wood with difficult shots, which were dealt with in splendid style. Shortly before half-time, Guy's again scored through Jones.

On resuming, the game was hotly contested. Both sides attacked in turn, and a good open game, in which there was plenty of passing, resulted.

There was not much to choose between the play of the opposing forwards, but our defence was much superior to that of our opponents. During the last twenty minutes Guy's were always on top, and obtained two more goals, once through Jones, who scored with a very good shot, and again by Witts, who netted the ball during a scrimmage round their goal.

REMARKS.—Wood in goal was brilliant, never making a mistake. Bastard and Johnson, at back, were quite safe, and they and Humm, by their vigorous tackling, did much to win the match. The halves were all good. Cook is beginning to get used to his new position, and fed his wing splendidly on Saturday. McManus, at centre, showed that he has a very good idea of the game. He has improved immensely since last season. Mitchell played a useful game during the first half, but deteriorated a good deal after the change of ends. Glover is better on the right wing than on the left, and passed well at times, but the centring of both wings left much to be desired.

GUY'S v. SURREY WANDERERS.

This match was played at Honor Oak Park, on Saturday, November 7th. Guy's started with ten men, one of our team scratching at the last minute.

From the kick-off our forwards got possession, and we were soon in the neighbourhood of our opponents' goal after a splendid run down the touch-line by King, whose centre, however, was somewhat erratic. The Wanderers, who had four of the Bucks playing, and whose especial strength is in their forward line, could make little headway against our defence, for whom Bastard and Edey were in magnificent form. Humm at centre half was playing a good spoiling game, giving their forwards little chance of settling down.

Play for some time was confined to mid-field, but after some time Guy's again pressed, the forwards having several opportunities to score, but their shooting was erratic and lacked power. Half-time arrived with the score 0—0.

At the re-start our left wing got possession, but made little headway. Jones tested their custodian with a good shot, but no score resulted. The same player a few minutes later had a grand opportunity of scoring, but their custodian intercepted the ball in a very lucky manner when a goal seemed certain. The Wanderers now got away through their left wing, and from a centre by F. Buck, H. Buck headed through, giving Wood no chance to save.

During a scramble round their goal one of their defence prevented an almost certain goal by punching the ball out. The Wanderers made several further attempts to increase their lead, but their forwards seemed quite overwhelmed by the vigorous tackling of Bastard and Edey, and were never able to settle down.

Towards the end of the game we again pressed our right wing, making some good runs down the field, but the efforts of our forwards lacked finish, and time was called with the score 0–1.

REMARKS.—Edey, at back, gave a brilliant display, showing that he has lost none of his former skill, while Bastard was, as usual, a tower of strength to his side. King made some fine runs down the touch-line and showed plenty of pace, but his centring was very erratic at times. So far this season not much success has attended our efforts, this being chiefly due to the lack of keenness of some of our team; on no occasion have we been able to turn out a representative eleven.

GUY'S 2ND XI. v. OLD WESTMINSTERS 2ND XI.

This match was played at Honor Oak on Saturday, October 31st, under fairly good conditions of weather, and resulted in a win for the Hospital by 2 goals to 1. Team:—

GUY'S.—H. C. Rook (goal); K. H. Hole, C. E. Reckitt (backs); E. L. Jones, J. A. Edmond, J. A. Ryle (half-backs); C. E. Rice, W. Wain, H. N. Eccles, R. Harrison, J. H. Campain (forwards).

GUY'S 2ND XI. v. ST. BART.'S 2ND XI.

This match was played at Honor Oak on Wednesday, November 11th, and ended in a win for Guy's by 3 goals to nil. Team:—

GUY'S.—H. C. Rook (goal); H. R. Bastard and H. J. Keer (backs); H. Harrison, P. S. Humm and R. A. Rankine (halves); C. E. Rice, D. Wain, G. Campain, R. M. King and D. A. Mitchell (forwards).

We regret that lack of space prevents our giving fuller reports of these 2nd XI. matches.

United Hospitals' Hare & Hounds

The annual general meeting of the United Hospitals' Hare and Hounds was held at Blackheath on Saturday, October 31st. The financial condition of the club was shown to be prosperous. Mr. Haselgrave, the Secretary of the Blackheath Harriers, has once again kindly given to hospital men the use of the "Green Man" dressing rooms.

It is hoped that all men interested in Cross Country running will turn out any Saturday at 2.30 p.m., and that by March next we shall be in a fit condition to win back the Inter-Hospital Cup, which was lost by such a narrow margin by us last year to the London Hospital. Freshmen are especially invited.

Birth.

POLLOCK.—On October 25th, at Valetta, Malta, the wife of Major C. E. Pollock, R.A.M.C., of a son.

Death.

ARCHER.—On October 19th, at Holmlea, Walthamstow, E. R. B. Archer, M.R.C.S. Eng., L.S.A., aged 46 years.

EDS.—L. M. & A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

November.

Sat. 28. 1st XV. v. Newton Abbot (Away).
2nd XV. v. K. C. S. Old Boys (Away).
1st XI. v. Old Citizens (Home).
2nd XI. v. Wanderers "A" (Away).

Mon. 30. Clinical Lecture by Mr. Bellingham Smith (Gynæcology), 1.15 p.m.

December.

Wed. 2. 1st XI. v. Casuals (Home).

Thur. 3. Messrs. Symonds and Steward's Take-in (Messrs. Sanford and Ewing).

Sat. 5. 1st XV. v. Northampton (Away).
2nd XV. v. Rosslyn Park (Home).
1st XI. v. Old Malvernians (Home).
2nd XI. v. Middlesex County Asylum (Away).
Debating Society's meeting at 8 p.m.—"That this House believes that the pursuit of Science diminishes one's appreciation of Art." Mr. Ormond in the Chair.

Mon. 7. Clinical Lecture by Mr. Ormond (Ophthalmology), 1.15 p.m.

Thur. 10. Messrs. Lane and Fagge's Take-in (Messrs. Dryland and Ball).

Passim.

WE offer our heartiest congratulations to Mr. H. O. Brookhouse, who in the recent examination for the M.B., B.S. London, achieved a brilliant success by obtaining honours in three of the subjects of the examination, and was awarded the University Medal. Congratulations are also due to Messrs. Janmahomed and Townrow, both of whom passed with honours in Medicine in the same examination.

DR. SHAW, in his opening lecture on Medicine, made some remarks which give one furiously to think. Referring to the question of compulsory lectures, he commented on the fact that the medical students of London have no organisation by means of which they could approach the examining bodies with a view to the redress of grievances or the adoption of reforms. It is certainly remarkable that no such organisation exists, but it is equally certain that it is not for lack of grievances or of advocated reforms. Probably the despair of ever being able to influence the established order of things is responsible for some of this apathy; possibly, in a very few cases, a conviction that the established order is incapable of improvement may contribute, but we think that a broader basis for it may be found in the fact that, while students in some countries are a political power, in this country (except to a slight extent in the Scotch Universities) they are politically negligible. The whole body of medical students has, as such, not the slightest voice on any responsible body, official or otherwise; whether anybody is the loser by this state of affairs is "another story."

WITH reference to the Officers' Training Corps, which has previously been mentioned in these columns, we are requested to state that a meeting will be held to consider the scheme on December 8th, at 4.30 p.m., in the Great Hall of London University. The Vice-Chancellor (Sir William Collins, M.P.) will preside, and the Secretary of State for War (the Rt. Hon. R. B. Haldane, M.P.) will address those gentlemen who are intending to enter the proposed corps, or who are interested in the question.

A NEW field of enterprise—semi-officially in connection with London University—has recently been initiated. The first University Hall of Residence is to be established at Chelsea under the Wardenship of Professor Geddes, and financed by a company known as the University and City Association of London (Limited). The scheme, which has received the Senate's blessing, will, moreover, be of interest to all Londoners, whether they take any interest in the University or not, for the London County Council have agreed to the incorporation of the fabric of the recently demolished Crosby Hall in the new buildings. The site at Chelsea occupies a portion of what was Sir Thomas More's country garden, and as he was one of the most illustrious of the former owners of Crosby Hall, the historical associations of the place will be doubly interesting. It is most appropriate, too, that this historic building should become associated with a scheme of this nature, and as it is stated that the materials of which the Hall was built are still in excellent condition, there is no reason why it should not have as long a career on its new site and among its new surroundings as it has already had amid the old. When completed, the new Hall of Residence is to accommodate about one hundred students, and the cost of its completion and equipment is estimated at £100,000, of which the re-erection of Crosby Hall will account for about £12,000. It is intended that the Hall shall be on a self-supporting basis, and it is proposed to complete the scheme in stages as the finances of the company shall permit. The promoters of the scheme are confident of its success, and they say that "it must attract not only those who seek for the student in whom they are immediately interested the advantages of the great city, whilst guarding against its dangers, but all who recognise that the metropolitan and imperial University, now in so many ways entering upon unprecedented developments, should not continue to lack that collegiate life which has been so valuable and characteristic an element of the older English Universities." We trust that the new scheme may meet with all the success it deserves.

WE note with interest that Mr. Bryden Glendining, M.B., B.S., has been appointed to the "Walter Emden" Scholarship in the Cancer Research Laboratories at the Middlesex Hospital.

A propos of our remarks in "Passim" for October 31st on the admission of women to the examinations held by the Royal College of Surgeons, a correspondent signing himself "Justitiæ Amator" writes complaining that, although a poll of the Fellows and Members was taken on the subject, the holders of the L.D.S. were in no way consulted, and yet the new regulation will apply to their diploma also. While we sympathise with our correspondent for what he calls this "great slight," we would point out that he seems to have a misconception as to the status of the Licentiates in Dental Surgery. The Royal College of Surgeons simply grants a licence to practise dentistry, comparable to the licence to practise medicine granted by the Royal College of Physicians, and in each case the granting of the licence confers on the holder no share in the constitution of the respective college. It is true (and we are constantly being reminded of the fact) that the Members of the Royal College of Surgeons have no direct share in the constitution of their college, but they have an annual meeting in conjunction with the Fellows, and certain privileges in which, under existing conditions, the Licentiates in Dental Surgery have no part.

THIS being the case, it was scarcely to be expected that the College should have taken a poll of the Dental Licentiates on the subject of the admission of women to the L.D.S. At the Annual Meeting in 1906, it was moved and seconded by Members "that when the question of admitting women to the College Examinations is brought before the Fellows and Members, this should be done by a poll of the Fellows and Members." It was never suggested, so far as we are aware, that a poll of the holders of the L.D.S. should be taken. In any case, the latter may console themselves with the reflection that, although the opinion of the Members was taken, it was not, as we have seen, adopted by the

Council, who acted independently of it. As regards the larger question—of granting licentiates in dental surgery a share in the constitution of the College—that, we imagine, must wait until the vexed question of the representation of Members has been settled, and at present there is no indication of any such settlement being near at hand.

SOME of our Christmas festivities at Guy's have been, and probably again will be, subjected to adverse criticism, but there is one function at any rate for which we imagine no one can have anything but the warmest approval. That function is the Out-patients' Tea, which brings probably the greatest good to the greatest number of any of the hospital Christmas attractions. Like every other undertaking of the kind, it needs financial support, and in appealing for this, we may confidently affirm that any one who subscribes to the tea, and also has an opportunity of seeing it in progress, will feel a glow of satisfaction at the sight of so much happiness to which he has contributed. Subscriptions will be warmly welcomed by any of the Out-patient officers — Messrs. Carlyll, Leeming, Tolhurst and Martyn Lobb.

WHILE on the subject of Christmas, we may remind our readers that tasteful and appropriate Christmas cards, printed by Messrs. Ash & Co., Ltd., similar to those which have been issued for two previous years, may again be obtained from the Librarian, or by Nurses from the Matron's Office. They are decorated with excellent views of the different parts of the hospital—the Quadrangle, College, Park, etc. The price of the cards is twopence each, including envelope, and the profit made on their sale will again go to the hospital funds; so that, besides affording a most convenient and acceptable form of Christmas greeting, they provide an indirect means of benefiting the hospital.

AN interesting little exhibition, open to any medical man on presentation of his card, is now on view at the Polyclinic in Chenies Street. It consists of a collection of drawings and plates illustrating the various lesions for which the "pallid spirochæte" is held responsible, especially some of the more unusual and doubtful primary manifestations. On Wednesday afternoons, from three to four, Sir Jonathan Hutchinson attends and gives an explanation of some of the exhibits, and medical men are thus afforded an opportunity of hearing the veteran surgeon, whose recent knighthood was so well merited, on the subject which he has made his life-study.

THE following amusing letter was sent to us by Mr. H. J. Henderson, into whose hands, as House Physician for the week, it recently came:—

To the Head Doctor
At Guy's Hospital, London.

Dear Sir,

About 3 months ago I wrote to you on Cancer, but I dont know whether you thought anything of it or not but I sincerely hope you kindly excuse me for doing so again.

* * * *

A man has little pricks or thistles in his body which is brought on by the acid we have in our body these are liable to develop and take root in any part of our body and the growth is nurished (*sic*) on by the acid we have in our body. And as a rule Cancer is to be found more prevalent in the upper part as it is there we have the most blood therefore the most acid as well.

I remain dear Sir
Yours most obliging,
J—— J——

So now, of course, the pathology of cancer is quite plain, and apparently an active alkaline treatment is indicated in these cases! Meanwhile we have received a communication from a gentleman in Paris who writes:—"I seize this occasion to affirm once more my priority in the Treatment of Cancer by High-frequency Sparks and Effluvations before and after surgical operations—method since improperly called 'fulguration.'" We willingly accept this statement, but it seems to us that the efficacy of the treatment itself is of more importance than the priority of its discovery. It would be interesting to know whether the number of methods of "curing" cancer is greater than the number of "explanations" of its causation, or *vice versa*; in any case, they are both, like dukes in the Gilbert and Sullivan opera, worth three a penny.

A Note on the use of Radium.

Up to the present time the use of radium at Guy's Hospital has been practically confined to the treatment of very small rodent ulcers and nævi. While it was generally efficacious eventually, this treatment was so exceedingly tedious to the patient that during the past eighteen months it has scarcely been used, other methods having been found more useful. In Paris, however, where it was discovered, and where it can be obtained in greater quantities than elsewhere, it is used for treatment in relatively enormous amounts, with results that are of some interest. I have recently had opportunities, on two separate occasions, of seeing the use that is made of it there.

By careful study of its physical properties it has been found possible to reduce the risk of a burn—which, unless proper precautions are taken, may be as bad as a severe X-ray burn—to a minimum, while, at the same time, its useful action is scarcely affected. Instead of the radium being used in the form of a few grains of an earthy-looking substance, contained in a sealed glass tube, as is the case with the specimen which has been in use at Guy's, it is spread over a flat metal surface, to which it is fixed by means of a special kind of varnish, the size of the surface being, as a rule, proportioned to the quantity of radium used. When in use the radium is covered by layers of different substances, in order to cut off those rays which produce a dermatitis, and the whole bandaged or strapped to the part affected. As the majority of cases treated are in-patients at a hospital, it is usually applied to the part for periods varying from twelve to forty-eight hours. The treatment is absolutely painless, and causes no more inconvenience than would be produced by an ordinary bandage. The action of the radium is confined to the part with which it is in contact and the tissues deep to it, and if one or two long applications are given in rodent ulcers and epitheliomata an apparent cure will be produced in all except advanced cases.

In one case a large rodent ulcer involving the left cheek and side of the nose was apparently cured by two forty-hour applications. In another case a large rodent ulcer above the right zygoma, and spreading forward so as to involve the lower eye-lid, had had three treatments of twenty-four hours' each. It was then almost well, and was to have a fourth application, which would probably cure it. In a few cases, which were treated as out-patients, four to six hours treatment was given daily, The scars left were supple, and similar to the scar produced after a cure by X-rays.

Of even greater interest were several cases of epithelioma of the lip, all of which were inoperable, and which appeared to respond to treatment as readily as the rodent ulcers. In the majority of the cases the diagnosis had been confirmed by microscopical examination. One case, which was apparently cured, was an epithelioma which had measured 5 cms. in its transverse diameter. In thirty-three days from the commencement of treatment the growth had disappeared. When I saw the patient a few months later, there was a slightly depressed white scar, about one square cm. in extent, at the left side of the lower lip, and there was no sign of new growth anywhere. I saw six or eight similar cases which, when compared with the photos taken before treatment, were all doing well, and in each case it was expected that all signs of growth would clear up. In most of them enlarged glands were present under the lower jaw, and these were treated in the same way, and apparently with the same results as the ulcers.

Besides growth of the lip, I saw a recurrence after operation for growth of the upper jaw, a melanotic sarcoma below the left eye, and an epithelioma of the scalp. All these cases were doing well, and two or three I saw twice, with an interval of two months, much improved. The rest had left hospital between my two visits. The average time that they were kept in hospital was two months, but one case had been in five months. In this patient the whole of the lower lip was involved in a fine pinkish-white scar; but there was a good deal of salivation, due to growth inside the cheek, which had not, so far, been treated. As the treatment is new it is difficult to draw any conclusion as to the prognosis in these cases.

Radium is also used for all kinds of nævi, and it is especially useful for those occurring on the face. Port wine stains are completely decolourised, and as no destruction of the skin is produced, the results are very good. One case I saw had had a pulsating tumour in the middle of the forehead, which had cleared up under treatment, leaving a slightly-depressed area, which was noticeable only from being rather paler than the surrounding skin. The treatment of nævi is much shorter than that of malignant disease, a few exposures of an hour each being all that is necessary.

The physical properties of radium are of considerable importance from the point of view of treatment and in their relationship to X-rays. Radium is a substance which is continually giving off an emanation without appreciably losing weight. This emanation is composed of three kinds of radiation, which are named α, β, and γ rays. The α rays are particles of matter of the same size as an atom of hydrogen, and move with one-twentieth of the velocity of light. These properties are similar to those of the anodal rays produced in an X-ray tube. The β rays are from 1,000 to 2,000 times smaller than an atom of hydrogen, and travel with the velocity of light, and in these properties resemble the cathodal rays of an X-ray tube. Both α and β rays are deflected by a magnetic field. The γ rays differ from the other rays in not being particles of matter. They are vibrations of the ether, of very short wave length, and cannot be reflected or refracted, but always travel in a straight line, and no known body is absolutely opaque to them. In these properties they resemble X-rays.

The α rays have very little power of penetration and a relatively severe effect on the skin, while the γ rays are

very penetrating, but damage the skin comparatively slightly. The β rays are intermediate in effect. In the case of malignant disease it has been thought that the best results are obtained by using the γ rays only. In order to cut off the α and the β rays the radium is covered with a layer of lead foil before being placed on the patient. This layer is $\frac{1}{2}$ mm. in thickness, and cuts off all the α and almost all the β rays. The γ rays passing through the lead form some secondary rays, and to cut those off from the skin several layers of paper, gutta-percha tissue, and lint are used. These layers form a sort of filter, and all the cases of growth are treated in this way. In the case of nævi no lead is used, but otherwise the filter is the same.

If the theory that the γ and X-rays are similar be correct, it should be possible to obtain the same results with each, but practically the results obtained by radium are far superior, not only in regard to the certainty and ease with which they are procured, but also in regard to the time expended on treatment.

A very fine specimen of radium has recently been obtained for the hospital, but it has been in use too short a time for any definite results to be obtained.

C. E. I.

Dental News.

On Friday, November 13th, a meeting of the Dental Society was held, the President, Mr. Spiller, in the chair. The minutes of the last meeting having been read and confirmed, casual communications were asked for.

The President exhibited :—

(*a*) A model showing a small sessile growth in the central incisor region, which, on removal and microscopical examination, proved to be a round-celled sarcoma; the maxilla and portion of soft tissues round the growth were further removed, and at present, eight months after operation, the growth has not recurred.

(*b*) A model showing an upper right canine tooth erupted behind the first premolar tooth of the same side.

(*c*) A model showing gouty exostosis of the upper right maxilla.

Mr. A. Hodgson, model showing marked attrition.

Mr. F. N. Doubleday :—

(*a*) A model showing three supplemental teeth in the upper incisor region.

(*b*) A model showing a supplemental tooth geminated with the right lower second premolar.

The President then called on Mr. Shepherd to read his paper on "Blue Light Analgesia." The paper was based on the work of Professor Redard in Switzerland, and of Mr. Harvey Hilliard at the Royal Dental Hospital.

Mr. Shepherd briefly reviewed the history of Blue Light Anæsthesia. He went on to describe the best apparatus and mode of producing anæsthesia with some account of certain theories as to its production.

After the paper, Mr. Poock, amid loud applause, offered himself as a subject for experiment; we understand that the chief impression made on him was that the apparatus was atrociously hot. A heated discussion on the paper took place, in which the President, with Mr. Dowsett and several members of the society, took part.

The general impression of the meeting seemed to be that the analgesia, when produced, was due to hypnotism.

We have received a pamphlet by Mr. Frank Coleman on the Nasal Administration of Nitrous Oxide.

The essential factor in Mr. Coleman's apparatus is that the administration takes place entirely through the nose, the mouth, if necessary, being covered by a mouth-piece provided with an expiratory valve.

An ordinary two-cylinder gas apparatus with brass union is used; a single tube connects this with the bag; beyond the bag is a stop-cock of special design, and from this double rubber tubes lead to the nose-piece and are connected to metal tubes in this, which, bending at right angles, allow the rubber tubes to pass back on either side of the patient's head, thus leaving the mouth quite free for the operator to work on.

A useful feature is a sliding clamp on the double rubber tubes which can be adjusted to the back of the patient's head, so automatically holding the nose-piece in position.

The stop-cock consists of an outer and an inner drum; by altering the position of the inner drum, gas, air, or a mixture of both is inhaled. The patient is instructed to breathe in through the nose and out by the mouth. For a mouth breather who tends to breathe in through the mouth as well as the nose, the mouth-piece can be applied to prevent this.

Both mouth and nose-piece are made of metal and can be sterilized.

Appointments.

Civil.

Doubleday, F. N., L.D.S. Eng., has been appointed Dental Surgeon to Farringdon General Dispensary and Lying-in Charity.

Sharpe, F. A., M.B., B.S. Lond., D.P.H., has been appointed Assistant Medical Officer of Health of the County Borough of Derby.

Naval and Military.

Staff-Surgeon J. C. G. Reed, R.N., has been appointed to the *President*, additional, for Yarmouth Naval Hospital.

Surgeon A. T. Rivers, R.N., has been appointed to the *Pembroke*, additional, for disposal.

Major H. St. J. Fraser, I.M.S., has been transferred to the temporary Half-pay List.

University of Cambridge.—Dr. Frederick Taylor has been appointed an Examiner in Medicine in the Third M.B., Part II.

University of London.—Dr. P. H. Pye-Smith has been re-appointed to represent the University on the General Medical Council.

Pass List.

UNIVERSITY OF LONDON.—M.B., B.S. Examination for Internal and External Students.—Honours: H. O. Brookhouse (*a*, *d*, *e*, University Medal), H. I. Janmahomed (*a*), V. Townrow (*a*). Pass: C. A. Basker, G. B. Harland, H. J. Henderson, K. H. Hole, W. Johnson, H. B. Kent, D. Reynolds, H. A. Sanford. Supplementary Pass List.—Group I.: R. C. V. Edsall, W. P. H. Munden. Group II.: L. T. Baker, H. C. Lucey.

(*a*) Distinguished in Medicine.

(*d*) Distinguished in Surgery.

(*e*) Distinguished in Midwifery and Diseases of Women.

ROYAL COLLEGE OF SURGEONS OF ENGLAND:—

Diploma of Fellow.—First Professional Examination, November, 1908: Frank Cook.

Final Examination for the Licence in Dental Surgery, November, 1908.—Parts I. and II.: *H. V. Gibbons, *W. E. Guilding, *W. A. Hodgson, *W. S. Lacey, *D. B. Tasker, *E. A. Tomes. Part I. only: N. D. Clarke, R. C. Morgan, A. Macdonald Watson, J. D. George, D. Y. Hylton. Part II. only: *S. W. Charles, *P. C. Charlton, *L. B. Griffin, *F. O. Hume, *Newton James, *R. W. Morrell, *H. S. Pugh, *W. E. A. Tibbalds, *W. F. Whiteley.

* Denotes completion of examination.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Women and the L.D.S.

DEAR SIR,—May I encroach upon a small space in your valuable journal in order to draw attention to what I consider has been a great slight to all Licentiates of the Royal College of Surgeons of England?

I note, in your issue of October 31st, that the College has made the L.D.S. (as well as the F.R.C.S, and M.R.C.S. diplomas) open to women. A poll was taken, the Fellows' votes recording a majority of 288 in favour of the movement, the Members' a majority of 703 opposed to it (notwithstanding this, it was passed); *the Licentiates were not even asked their opinion.* "Is this cricket?"—Your obedient servant,

"JUSTITIÆ AMATOR."

[We refer to this letter in "Passim."—ED.]

Guy's Physiological Society.

AT a meeting of this Society, on Monday, November 16th, a paper was read by Mr. G. T. Mullally, entitled "Secretion of Milk." Mr. A. R. Thompson was in the chair.

The author purposely refrained from going into the general physiology of secretion, but devoted most of his attention to one or two points of special practical interest. The question has been raised, "Is the milk formed by a slow continuous process during the whole of the period of suckling?" or, "Is it by a quick active secretion going on only at the time when the offspring is being fed?" That milk is formed by a slow continuous process is obvious when one thinks of the cow; but still the answer to the second question is not altogether in the negative. In support of this the author produced several sets of figures giving the volumes of the udders of different cows before and after milking, and showed that the amount of milk drawn off was greater than the diminution in volume of the udder. Therefore, the secretion goes on more actively at the time of milking. Moreover, the capacity of the udder of a cow in full milk is practically the same as that of the same cow going dry: yet the yield of milk in the former case is about 8 litres per 12 hours, and in the second only about 4 litres in the same time. The active secretion under the stimulus of milking is therefore a very important factor in the case of a cow in full milk. An interesting anatomical point in this connection is that the mammary gland of a milch cow is drained by extra large superficial veins, which would seem to be designed to carry away the increased blood supply which would naturally attend this quick secretion.

The udder of a mare in full milk has a capacity of about 500 c.c. Such an animal, if its foal dies, needs milking about six times a day, and its yield of milk is about 6·8 litres per diem, an average of over a litre at each milking. As the capacity of the udder is only about 500 c.c., there must be a very active secretion under the influence of milking. The author gave facts and figures pointing to a similar condition in the goat.

In summing up, he called attention to the fact that for many generations the cow has been selectively bred for milking, the goat less so, and the mare (in these islands) not at all. The cow, therefore, cannot be used as a basis for generalisations; any inferences of a general nature should rather be drawn from the goat and the mare, and in these animals "the quick active secretion under the stimulus of milking would seem to be quite as important as the slow, continuous secretion occurring during the intervals between milking."

In the discussion which followed, the chairman was, unfortunately, able to take little part, his time being taken up in calling the Physiologists to order.

At the close of the meeting a sub-committee was elected, at the instigation of Dr. Pembrey, "to investigate the question of the secretion of milk in general and of pigeons' milk in particular."

Reviews, etc.

The price of books submitted for review should in every case be stated.

Points of Practice in the Maladies of the Heart. By Sir James Sawyer, M.D. (Cornish Brothers, Ltd., Birmingham.) Price 2s. 6d.

This little book is composed of the Lumleian Lectures recently delivered by Sir James Sawyer at the Royal College of Physicians. The distinguished author has been successful in compressing within the small compass of the book much valuable information and many practical points of wisdom.

Diseases of the Skin. By Sir Malcolm Morris, K.C.V.O., with the assistance of Dr. Ernest Dore. (Cassell & Co.) Fourth edition. Price 10s. 6d.

The last edition of this text-book was published in 1903, since which date there have been, as the author remarks, "numerous and not inconsiderable advances made in Dermatology," and these are embodied in the present edition, in most cases with references to the original papers. Such recent work as the serum diagnosis of syphilis, the treatment of syphilis by atoxyl and soamin, and of furunculosis by vaccines, the use of radium for the destruction of nævi, and the Calmette and Pirquet tests for tuberculosis, is among the new matter included, and the various changes have necessitated the introduction of some forty-eight additional pages.

Some new pictures, including eight satisfactory coloured plates, are also included in the present edition, and the *format* of the book has been altered with advantage. The characteristic feature of the index in showing at a glance the main lines of treatment for each disease has been retained.

Extraction of the Teeth. By Frank Coleman. (H. K. Lewis.) Price 3s.

Mr. Coleman is Assistant Dental Surgeon to St. Bartholomew's Hospital; he has, therefore, a special knowledge of the difficulties experienced by medical students in what may be a matter of importance to them in their general practice, *i.e.*, the extraction of a tooth, and has kept this especially in mind in writing his book. The book is also of great value to dental students; the illustrations are good, and the accompanying text is clearly expressed. We should like to have seen more space devoted to the consideration of local anæsthesia, since this daily becomes of greater value and more extended use in operative dental surgery.

The question of the complications following extractions is well and fully treated. The volume should be on the book-shelf of every student and practitioner.

Physiological Principles in Treatment. By W. Langdon Brown, M.D. Cantab., F.R.C.P., Physician to the Metropolitan Hospital, Medical Registrar and Demonstrator of Physiology, St. Bartholomew's Hospital. (Baillière, Tindall & Cox.) Price 5s. net.

The publication of this excellent little book may be taken as new evidence of a growing tendency to bring the teaching of physiology into closer touch with clinical work—a tendency which is evidenced also by the new regulations for the London M.B., which state that in physiology "special stress will be laid on such methods as are applicable to man or have bearing on the subsequent work of the student." Applied anatomy has, of course, long been recognised as a subject for text-books; physiology is now being applied; in the future we may have text-books on applied pathology. The very existence, of course, of such books shows that our system of medical education is still quite unscientific. Pure anatomy and physiology are taught in one department by one set of teachers, and the practical applications of those sciences in another department by another set. In this way an attitude of aloofness from practical work has sometimes been taken up by the teachers of pure science, on the one hand, and an attitude of contempt or indifference on the part of the practical men towards the results of pure science on the other.

In physiology these conflicting influences have been very manifest. The rapid strides made in this science during the early part of the 19th century caused a great enthusiasm for scientific medicine, which led Claude Bernard to declare that " . . Scientific medicine has got hold of all our younger men: every day it gains ground, and will establish itself against all its critics." Then, later, pure science began to adopt a somewhat domineering attitude towards clinical medicine, and this brought about a great revulsion of feeling on the part of the practical workers, so that, as Dr. Langdon Brown remarks in his preface, "the physiologist is still regarded a little suspiciously at the bedside. Perhaps he is in part himself to blame for that, for he is sometimes inclined to forget that observations made in the laboratory are not infallible, and are not necessarily more correct than clinical evidence." We hope and believe that a more reasonable and amicable understanding between the physician and the physiologist is gradually becoming more evident, and it will be to their mutual advantage. Alone, either of them can do little; together, they might do much.

The book before us is a praiseworthy attempt to foster this conciliatory attitude of mind. The author has applied physiological principles to the consideration of some problems in treatment, but in reading the book one is once again struck by the impossibility of dealing with treatment without at the same time considering etiology, pathology and diagnosis, and a good part of this book, in spite of its title, is devoted to these subjects. Of course, the book is in no sense a complete treatise on applied physiology, nor does it pretend to be such; it treats only of certain special problems in medicine, such as "Irregular Action of the Heart," "The Rational Treatment of Gastric Disorders," "The Rôle of Calcium in the Body," and "The Work of the Pancreas."

Selecting one or two points at random, we note that the author puts forward a very strong plea for systematic use of blood-pressure estimations as an aid to diagnosis and prognosis and a guide to treatment in heart cases. He advocates the Lenhartz method of feeding by the mouth throughout, rather than rectal feeding, in gastric ulcer, and has been "most favourably impressed by that method." In speaking of functional albuminuria he recommends that candidates for life insurance who are subject to it should be fortified "against the ordeal of examination by administering calcium lactate" (15 grs. three times a day) "which should control the albumin in these cases." Although he quotes many new theories which, to say the least, have but a flimsy basis, the author maintains a very engaging scepticism, and he sometimes gives rein to that sense of humour so invaluable in physician and physiologist alike. Some useful summaries are given at the ends of the chapters, and a list of the principal references, mainly to works published in English and easily accessible.

In conclusion, we may say that the book might well be longer than it is; chapters on pyrexia and œdema, for instance, would almost certainly be interesting. We hope that a second edition may afford Dr. Langdon Brown an opportunity of extending what, in its present form, is already an admirable book.

Periodicals received.—St. George's Hospital Gazette; The Polyclinic; The Hospital; The Clinical Journal; St. Mary's Hospital Gazette; The Prescriber; The Manchester Medical Students' Gazette; Manchester University Magazine.

Papers by Guy's Men.

Three Lectures on the Pathology and Treatment of Diabetes Mellitus, viewed by the Light of Present Day Knowledge. Lecture I. By F. W. Pavy, M.D. Lond. LL.D. Glasg., F.R.S.—*The Lancet*, 21st November, 1908.

An Address on Mental Cripples. By George H. Savage, M.D. Lond., F.R.C.P. Lond.—*British Medical Journal*, 14th November, 1908.

Account of an Epidemic of Enteritis caused by the "Liverpool Virus" Rat Poison. By Lionel Handson, M.B., B.S. Lond., and Herbert Williams, M.D.—*British Medical Journal*, 21st November, 1908.

The Action of Saline Purgatives. By A. F. Hertz, M.A., M.D. Oxon.—*The Lancet*, 14th November, 1908.

The attention of our readers is called to a notice which appears in our advertising columns with respect to the forthcoming volume of the "Guy's Hospital Reports." This, the sixty-second volume of the Reports, will be issued during the month of December.

The Library.

(From "Round the Hospital.")

This, stranger, is the House of Wills,
Ruled by the conscientious Mills,
Wherein we keep each cryptic screed
Physicians write and students read.

From half-past nine when opes the door,
'Tis quiet half an hour or more,
Save that each navvy's lusty pick
Rings on New Outers' pristine brick.

From ten to one the student horde
Tramp up and down its polished board.
The humourist to idle folk
Recounts aloud his latest joke.

And those who know their lesson well,
In penetrating whisper tell
Some friend of intellect less keen
The structure of leukæmic spleen.

An hour, perhaps, some nurse devotes
To Chopin, plus a few wrong notes.
A fair soprano whiles away
Ten minutes with "Two Eyes of Grey."

Lest afternoon be quiet and dumb,
The convalescing children come
In search of exercise, and lark
Within our wide expanse of park.

Beneath the open casement-holes
They shoot imaginary goals,
And played by limping girls and boys
Are games, whose one essential 's noise.

Here, too, the student will attend
A sister, aunt or lady friend,
Who never fails to let him know
How nice it is, *fortissimo*.

Then I surrender to the din,
Then slam my Gray and Galabin,
Don hat, and fly with savage oath
To alcohol, or bed, or both.

Praise, stranger, praise the generous Wills,
Salute the none too slender Mills,
But pity us who hither come
To find "*quies silentium*."

S. S.

The Inguinal Operation for Femoral Hernia.

By Dr. N. Bardescu, Surgeon to the Brancoveanu Hospital in Bukarest.

(Translated from the German.)

I.

In the operation for femoral hernia, as in the operations for all other varieties of hernia, it has been taken as an axiom that one should cut down directly on the affected region, regardless of the organs which may lie in it, of the size of the protrusion, and of other associated conditions, such as reducibility or the contrary, of the presence of inflammation or of strangulation; in all these cases one is given to understand that the operation should be performed directly through the femoral region.

In spite of the progress which has been made in operative technique and the diversity of the methods employed, this procedure has proved far from satisfactory, and especially so when it is our object to carry out a simple operation. We have, indeed, to work in a deep-seated region, which does not allow of our dealing with the sac and its contents according to sound operative principles; nor can we determine the position of the organs which lie in the abdominal cavity beyond the hernial sac. Further, the resection of the sac and the complete anatomical closure of the crural canal, which is all-important in the radical operation, can only be carried out with difficulty by the femoral route. In nearly all cases resection of the sac is limited to that portion which presents in the thigh, as it is impossible to follow it up further into the abdominal cavity; no easier is it to place a suture through the crural canal, for which reason some operators renounce all attempts at suturing and perform plastic operations with a view to closing the orifice.

For several years I have performed the indirect operation through the inguinal region, and, as a result of considerable experience, I have come to consider this method much superior to the direct, or femoral, and this not only because of the advantages it offers as regards the field of operation, but also because, under favourable conditions, a radical cure is guaranteed.

The operation was performed for the first time on January 14th, 1876, by Annandale, in Edinburgh. The case was one of double hernia—a femoral as well as an inguinal—upon one side. After having carried out the operation for the inguinal hernia, he proceeded to deal with the femoral hernia from the inguinal region. The procedure was adapted to the circumstances; nevertheless, the result was highly satisfactory.[1] A year later, Annandale decided to employ the inguinal method in a second case—one of simple femoral hernia this time. The patient was completely cured, and shown before the Edinburgh Medical Society on April 4th. Annandale's example was not followed until a good deal later, when Giuseppe Ruggi[2] lectured upon the inguinal method before the Medico-Chirurgical Society of Bologna, on March 11th, 1892. Ruggi systematized the technique of the operation, and tried to prove that femoral herniæ can be better treated by the inguinal route. After this the inguinal method began to be studied and put into practice by others, such as Parlavecchio,[3] Tuffier,[4] Vallas,[5] and Delbet,[6] who have published their cases. And yet, notwithstanding the good results obtained, the operation was only looked upon as being indicated in exceptional cases, the routine method still remaining the direct, or femoral.

Personally, I have used the inguinal method since 1896, at first with some reserve, so that, in my publications of 1899[8] and 1902,[9] I had limited the indications for this operation to cases of combined femoral and inguinal hernia on the same side, and to cases of femoral herniæ in men with weak abdominal walls; I considered the method less clearly indicated in cases of simple femoral herniæ in women and in strangulated herniæ. In the course of years these

[1] *Edinburgh Medical Journal*, June, 1876. In Annandale's patient there were two large reducible herniæ on the same side, one a femoral and the other an oblique inguinal. At the time of the operation the sac of the latter was empty, and adherent to it was the sac of an old direct inguinal hernia. The two sacs were included in a ligature, which was placed as high up as possible, but they were not cut off. Meanwhile the femoral sac had slipped up and disappeared from view. The enlarged crural canal was closed by drawing the two inguinal sacs down into it, and fixing them in this position by a suture, the free ends of which pierced the tissues of the thigh and were tied externally. Dr. Bardescu errs when he speaks of the result as "highly satisfactory," for, as we should expect, recurrence was not long delayed.—V.St.J.

[2] Del metode ing. nella cura radicale dell ernia crurale. Bologna, 1893.

[3] Riforma Medica, 1893, p. 496.

[4] Revue de Chirurgie, 1896.

[5] Dussuc, Thesis. Lyon, 1901.

[6] Guinement, Thesis. Paris, 1901.

[7] Ghiulamila, Thesis. Bukarest, 1902.

[8] N. Bardescu, Spitalul. Bukarest, 1899, p. 427.

[9] N. Bardescu, Revista de Chirurgia. Bukarest, 1902, p. 177.

restrictions have vanished; experience has overcome all reserve. Now I employ the inguinal method in all cases, and prefer it to other methods.

If we examine the indications, we see that, in the first category, in which the femoral hernia is complicated by the presence of an inguinal hernia on the same side, or of a weak abdominal wall, the most favourable conditions are offered for the carrying out of the inguinal operation, as by this means both ruptures are dealt with at the same time, whereas, by following the principle of the direct method, each rupture would have to be dealt with separately. No less well-founded do the indications now seem to me with regard to the second category, which includes simple herniæ in women and strangulated herniæ. In these cases one would naturally be inclined to expect greater difficulties, or post-operative weakening of the inguinal region, or, in cases of strangulation, some danger to the peritoneal cavity. But experience has taught that such apprehensions are unfounded. Especially in strangulated herniæ is the clear field of vision provided by the inguinal method of great advantage, as it allows of our actually seeing the strangulated organs. Thus, I had a case in which, in addition to the strangulated organs, a portion of the bladder wall was present, which in any case could not have been recognised before the inguinal canal was laid open. The same applies to another case, in which the Fallopian tube was included in the sac of a strangulated hernia. Even when there is strangulation of bowel or omentum, I consider it more suitable to examine the organs through the abdominal cavity, instead of limiting my examination to the organs which lie in the hernial sac.

The inguinal method has been employed in all of the last twenty-two cases which came under my care, the operation being performed twenty-three times. I will now proceed to describe it in detail.

II.

The operation is performed under general or spinal anæsthesia. In those cases in which there is great distension of intestine, which either incommodates us or threatens to protrude, we employ, during the stage at which the peritoneum of the inguinal region is opened, the position suggested by Trendelenburg, which allows the coils of bowel to fall away.

The steps of the operation are as follows:—

1. *Incision of the superficial tissues and isolation of the hernial sac.*—First identify the anterior superior iliac spine, the pubic spine and Poupart's ligament. Between the iliac spine and the spine of the pubis make an incision parallel to, and one finger's breadth above, Poupart's ligament. Carry it down as far as the aponeurosis of the external oblique. Vessels are seized with pressure-forceps. The length of the incision, measured from the external ring, should be about 10 c.m.; but it will depend to some extent upon the development of the superficial fat. The incision having been made, the lower edge of the wound is separated with one finger and the hernial sac is reached. The latter is now isolated and prepared and followed up as far as possible under Poupart's ligament. The scissors are rarely necessary either to loosen the cribriform fascia or to divide more resistant and thickened tissues. There are no difficulties to encounter; the incision is convenient, and I have never found it necessary to alter the direction of the incision or to add a second one. In preparing the sac one should be careful of the femoral vessels, especially if the former should happen to be thickened.

2. *Opening of the inguinal canal.*—The aponeurosis of the external oblique is laid open with the scissors, commencing its division at the external ring and carrying it through the whole length of the inguinal canal. The internal oblique and transversalis muscles are pushed upwards, while the cord is isolated and drawn inwards; similarly, in the female, the round ligament and its coverings are drawn inwards, without our attempting to isolate the same. The deep epigastric vessels may be seen running beneath the transversalis fascia or they may be recognised by palpation in the wound. To their inner side the transversalis fascia is opened, so that we come directly upon the crural ring above the hernial sac. If the epigastric vessels prevent a further opening of the fascia transversalis they may be divided between two ligatures.

3. *Treatment of the sac and its contents.*—We now proceed with the preparation of the sac through the opening made in the transversalis fascia until we can bring it perfectly freed beneath Poupart's ligament into the inguinal region. This is easily done with reducible herniæ or with those that are small in size. But if the hernia is very large, so that it cannot be brought back through the crural canal, then we must first open the peritoneum through the inguinal region, reduce the contents of the sac, and, lastly, the sac itself. Should, in such cases, the contents consist of large masses of thickened and irreducible omentum, then we must ligature and divide the latter

through the inguinal opening, and remove both sac and omentum through the region of the thigh. The omentum is treated in the same way in cases of strangulation.

In cases of strangulated hernia of the bowel, the sac is opened through the thigh, and the fluid contents are mopped up with sterile sponges. The abdominal cavity is next opened through the inguinal region, the parts are examined, the cause of the strangulation removed, and the bowel reduced. Any lesion which may happen to be present is now treated, the abdominal cavity being first carefully isolated by means of sterilised compresses. The omentum is only cut off if it is present in the sac or if it is visible in the wound. On no account should it be followed up into the abdominal cavity.

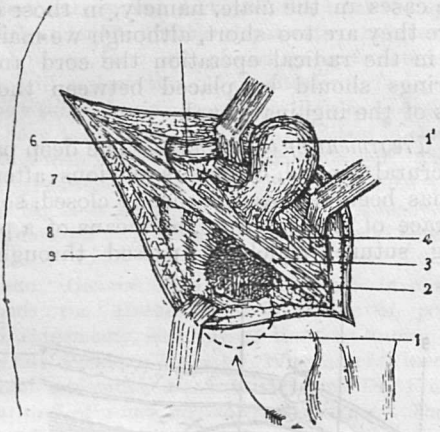

FIG. I.

Fig. I. shows diagrammatically the appearance of the inguinal and femoral regions at this stage of the operation. The sac (1^1) is seen after it has been drawn over the inguinal region, to the inner side of the deep epigastric vessels (7). In the femoral region the position originally occupied by the hernial sac (1) next to the femoral vessels (8, 9) is indicated, as well as the orifice (2) through which it was transferred to the inguinal region.

After the contents of the sac have been dealt with as indicated, the now empty sac is freed as far up as possible in the abdominal cavity, ligatured with catgut and divided. The peritoneal cavity is thus entirely closed and the treatment of the hernia is completed. Now we have only to deal with the wound and to ensure a radical cure where this is indicated.

4. *Closing the crural ring.*—When the sac has been resected the ligament of Cooper should be sought and defined (Fig. II., 10), and likewise Poupart's ligament (Fig. II., 3). A thick catgut suture should then be introduced with a curved Reverdin's needle, in the form of a U, which embraces almost the whole crural ring (Fig. II., 11.). By means of this suture Poupart's ligament is brought into intimate

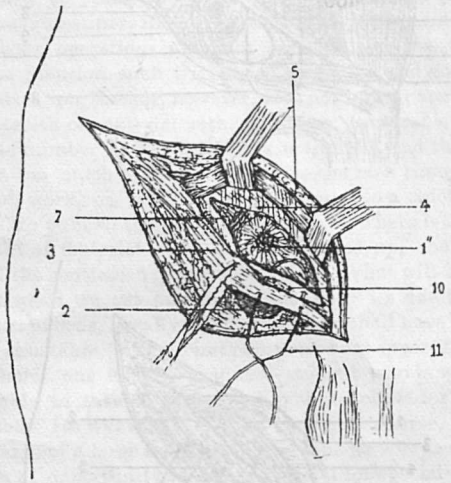

Fig. II.

contact with Cooper's, and the crural ring is thereby completely closed. Should the orifice not be perfectly obliterated, then an ordinary suture may be introduced higher up in the ligaments. I have never found this additional suture necessary.

This closure of the femoral orifice is brought about through the inguinal region, and, if the parts are under a good light, it is very simple, especially if Cooper's ligament is slightly detached from the bone by means of a director. The suture is first passed through Cooper's ligament and then through Poupart's, as seen in Fig. II. When the needle is passed the femoral vessels should be protected by pushing them outwards with the left forefinger.

Fig. III. (2) shows how the femoral orifice is closed, as would be seen from the abdominal cavity.

5. *Reconstruction of the abdominal wall.*—This step is undertaken whenever we wish to effect a radical cure, and it is unnecessary to leave the wound open, as, *e.g.*, in septic strangulated herniæ. The abdominal wall should be decidedly strengthened by the operation. As a rule, I use Bassini's method, as in the radical cure of inguinal hernia. First, the fascia transversalis is sewn over the stump of the sac. Thereupon the lower border of the adjacent Poupart's ligament is sewn to the conjoined tendon by three

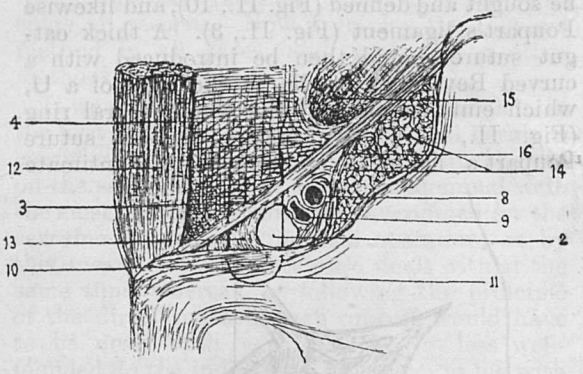

FIG. III.

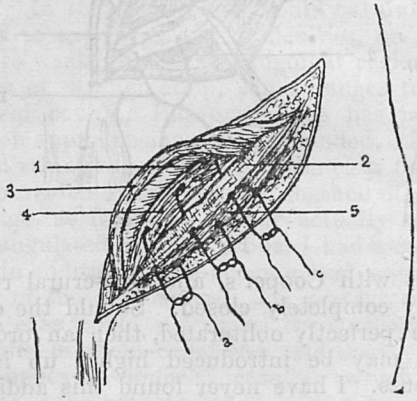

FIG. IV.

or four mattrass sutures, so that the ligament is enclosed by the sutures, and the knots, when tied, are directed outwards. These layers form the posterior wall of the inguinal canal behind the cord. Fig. IV. shows how the sutures are passed between the conjoined tendon (4) and Poupart's ligament (5).

The cord and its coverings are placed upon the superficial aspect of the posterior wall, while the anterior wall is reconstructed by suturing the aponeurosis of the external oblique.

When this aponeurosis is weak and thin, the anterior wall is strengthened by superimposing the inner portion of the aponeurosis over the outer. I have always laid particular stress upon this procedure, because it plays a great rôle in strengthening the inguinal wall and in preventing the recurrence of the hernia. Fig. V. shows how the layers of the aponeurosis are made to overlap.

In the female I leave the round ligament behind the posterior wall of the inguinal canal.

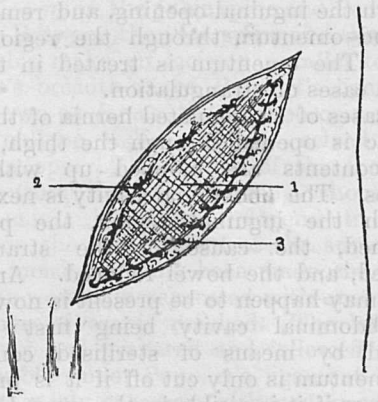

FIG. V.

Similarly I treat the cord and its coverings in some cases in the male, namely, in those cases where they are too short, although we maintain that in the radical operation the cord and its coverings should be placed between the two walls of the inguinal canal.

6. *Treatment of the wound.*—The deep part of the crural wound, which is obvious after the sac has been removed, is firmly closed, so that all trace of it disappears, by means of a purse-string suture, which is passed through the

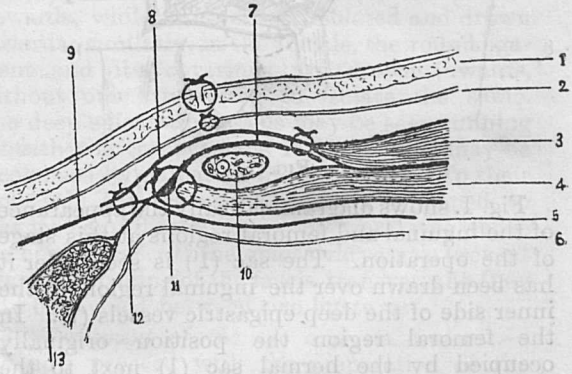

FIG. VI.

aponeurotic parts surrounding it. The further treatment of the wound need not be described.

Fig VI. shows in sagittal section the completed operation, and the nature of the reconstruction of the walls of the inguinal canal.

BOOKS RECEIVED.—Allen's Vaccine and the Opsonic Method, 2nd edition; Goodall and Washbourn's Infectious Diseases; Sir Malcolm Morris' Diseases of the Skin; Langdon Brown's Physiology in Treatment.

Notes of a Roving Guy's Man.*

X.

At the Allgemeines Krankenhaus at Graz there is as much to be seen and to be noted as at the Children's Hospital, and in addition there are the large City hospital and the fine infirmary of the Barmherzige Brüder. This last is one of the best and most modern of the many excellent institutions owned by the Order, its surgical side being particularly well developed. The General Infirmary, which is the University Clinic, is an old building, not particularly interesting as a specimen of hospital construction, and built on much the same plan as the large infirmaries at Prague and Vienna, that is, in the block corridor style with central open spaces and side wards. With these institutions it shares the disadvantages which are inseparable from such a model. The wards are insufficiently ventilated and lighted, the corridors narrow and dark, and the total bed space is insufficient for the number of patients. In a few years' time, however, Graz will possess an up-to-date hospital which will replace this old institution. The plans of this new surgical clinic leave very little to be desired, as they have been drawn up by the architect in close consultation with Professor von Hacker himself. The new building is situate just outside the city boundary, and is as yet far from complete, but when it is ready, it will easily hold its own with the new clinics at Greifswald and Berlin.

At the "General" the surgical side is in charge of Professor von Hacker, the originator of posterior gastro-jejunostomy, and one of the best-known pupils of the late Professor Billroth. With him are associated the chief assistants, Dr. Streissler and Dr. Finsterer, and a staff of some half-dozen assistants. The Out-patient Department is in charge of chief assistant Dr. Fischer and a staff of junior assistants. The small orthopædic department is supervised by Dr. Wittek. The work at this clinic is most interesting, and at no other centre can one see so many interesting cases. This is due to the fact that the clinical material is unusually rich, and that it is concentrated. At the General Hospital at Vienna, there are no less than four surgical clinics, and the result is that the material is distributed fairly evenly, no clinic obtaining a large number of cases. At Bier's clinic, which one can justly compare with Von Hacker's, there is a similar concentration and an equally large amount of material, although the number of occupied beds is fewer. At the Graz surgical clinic the number of occupied beds is 230, an unusually large number when it is remembered that these are all in charge of one chief. The result of this concentration is that there is plenty to do. At no other clinic have the assistants so many opportunities for practical work, and even when one is familiar with the custom that prevails at Austrian hospitals where all the assistants are given major operations, one is astonished to find how much here falls to the lot of the juniors; many very interesting ones are done, even by them. Thus, at my first visit, a junior assistant did a total extirpation of a mammary carcinoma, with division of the clavicle and complete clearing out of the supra-clavicular glands—an operation which at Berlin would certainly be reserved for the chief. Resections of gangrenous intestines, intestinal anastomosis, laparotomies and bone operations are here done by the assistants, not to mention such trivialities as herniæ and goitres! Professor von Hacker, however, does not appear to regard this wealth of material with altogether favourable eyes, for the number of his assistants is limited, and there is *really too much work to do to give the men time to do* special work, or, what is of importance to a chief of a clinic, to publish the results of cases. "There is a vast amount of material waiting to be worked up," he says, "and the gentlemen get no time for it. What will be the result when we get our new clinic, with its additional number of beds, I really do not know; we shall have to get more assistants." I need not point out what opportunities this holds out for the graduate student who is willing and able to take an assistantship at the clinic for some months. He will find the work heavy, of course, being in charge of a large number of beds, but he will also find plenty of opportunity for operating and for special work. A knowledge of German is, of course, requisite, but the student need not, as at present in Germany, be a practitioner who has done the State examination. He must be qualified and do duty as a junior assistant, unpaid, and under the chief assistants. As in Germany, he will find the assistants all very friendly and helpful, while, as I have already stated in a former letter, the relations between the chiefs and the juniors are much more human and fraternal than is the case in Germany. For the man who only wishes to do post-graduate study, that is to say, to work as the majority of English-speaking students do at Munich or Vienna, Graz offers excellent opportunities. Both the Professor and Dr. Streissler speak English, and both lecture and demonstrate. Dr. Streissler tells me he is perfectly willing to give post-graduate courses to English graduates on lines similar to those at Berlin and Vienna, and I feel perfectly sure that Graz will become a popular centre when foreign students know what advantages a short sojourn at its fine clinics holds out. This is equally much the case in the other departments, of which I may specially mention the neurological clinic in charge of Professor Hartmann, and the first medical clinic in charge of Professor Lorenz. For research purposes there are large, and comparatively new, physiological and chemical university laboratories, an anatomical and experimental biological institute, and facilities for looking up the literature on any subject. Living is, on the whole, cheap and good, and during the winter term there are many social attractions. In summer there are three main attractions, outside clinical work, that will appeal to graduate students—the excellent

*Series I., II., III., IV., V., VI., VII., VIII., and IX., of Notes appeared in Gazette of April 4th, May 2nd, May 16th, June 13th, August 8th, August 22nd, September 5th, October 3rd, and November 14th.

opportunities for mountaineering, for fishing, and for shooting. The Styrian mountains are comparatively little known to the English climber, but they offer scope for as splendid excursions, whether real climbing, glacier and ice work, or mere "walking ascents," as do the Swiss and Italian or Tyrolean Alps. An undoubted advantage which they possess over these is the fact that such excursions need not exhaust the moderate capital of the student climber as they do in Switzerland, where an ascent of any of the better-known peaks means an outlay which is practically prohibitive to the average student. Here in Styria the "peak huts" are cheap and comfortable, guides reasonable, and "base charges" equally much so. For beauty and variety of scenery the Styrian Alps are hardly to be surpassed, even if they are not so high as their rivals on the west. Peaks like the Dachstein and Gross Glockner, both well above 9,000 feet, and both with fine glacier routes, are well worthy the consideration of the Alpine climber, while farther afield the wildly picturesque Dolomites have points which make them particularly attractive to the mountaineer. Fishing, both trout and coarse, is excellent, although usually preserved. Still, the rates are not extravagant and the sport is fully equal to that which can be obtained in, say, Devonshire. Most of the shooting is leasehold, but a partnership holding can readily be obtained for what is a comparatively small sum when one considers that this includes not only hare, rabbit, partridge, and pheasant shooting, but grouse, capercailzie, ptarmigan and deer as well. The man who wishes to combine business and study with pleasure cannot do better than come to Graz for a few months during the summer. He will find his hands full, and will regretfully leave the place with the firm determination to repeat his visit as soon as opportunity offers.

But to return to the surgical clinic. The operating room is a large and well-lighted theatre, with overhead light, furnished, as at Prague, by a double glass roof. The inordinate heat that results from this arrangement is largely counteracted by a steady stream of water which courses down the glass roof from early morning till late in the afternoon during the summer months, and even on the hottest day the temperature of the theatre is never unbearable. Two or three operations are usually done at the same time, and the lavatory accommodation is thoroughly adequate for so large a room. A good many of the operations (one may say the majority) are done under spinal anæsthesia, which is here carried out in the best manner I have yet seen. The various methods used in other clinics are all open to disadvantages. Thus there is no necessity whatever to tilt the patient upside down, or to use a special fluid medium such as Barker's solution. Again, the method at Berlin of injecting a comparatively large amount of even normal saline fluid and thoroughly mixing this with the cerebro-spinal fluid by repeatedly filling and emptying the canula is open to objection. Stovaine is rightly condemned all along the line. It is a dangerous drug to use, not only because it may give rise to kidney trouble, but because its immediate after-effects are always somewhat doubtful.* As followed at von Hacker's clinic, the procedure is as follows:—An iridium-tipped canula and trocar, plated inside as well as outside,† is used. The site of puncture is carefully sterilised, first with soap and water, then with ether, and finally with alcohol, no iodine tincture being used. Then the exact spot is selected, and a nick is made with a small sharp scalpel. This prevents blunting of the trocar and the risk of a particle of epithelium being injected. The trocar is then thrust in and withdrawn, the cerebro-spinal fluid escaping in drops from the end of the canula. The syringe consists of a specially graduated glass tube, fitted with a ground-glass piston which occupies its whole lumen, but which is perforated by a thread bore, the end of which can be fitted to the canula. The whole apparatus is sterilised by dry heat, together with ·07 gramme of tropacocaine, which is put in the graduated glass cylinder. This latter is now held under the canula, the piston being removed, and 10 c.c. of cerebro-spinal fluid collected in it, which is thoroughly mixed with the tropacocaine by gently shaking the cylinder. The glass piston is then fitted to it, and its end is attached to the canula. All that remains is now gently to squeeze the piston backwards; the solution of tropacocaine in cerebro-spinal fluid escapes through the bore of the piston into the canula and so into the spinal theca, the piston accurately fitting the cylinder. When the whole has been injected, the canula is rapidly withdrawn and the puncture sealed in the usual manner, and a few minutes later the operation is proceeded with. The advantages of this method are obvious. The apparatus can be completely sterilised by dry heat, no foreign substance, except the tropacocaine, is injected into the spinal theca, and there is no dilution or alteration of pressure. Carefully done, not a drop of cerebro-spinal fluid is wasted. The results obtained are very good, the anæsthesia lasting more than an hour, and being very complete. Thus an umbilical hernia with extensive recto-plasty can easily be done under it. A large number of such injections have been made, as a routine measure, for many months past without the slightest bad result being observed, and the method certainly appears a great improvement upon the ordinary procedure.

As at Prague, one sees a very large number of goitre cases here, from children of ten to old women with ulcerating goitres. Intestinal cases, herniæ, new growths and breast cases are also relatively frequent. In the

*For all that, it is the drug most commonly used in England, though Tuffier, who first employed it, no longer makes use of it. One finds, on reading an English article on spinal anæsthesia, based on 40 or 50 successful cases, that stovaine is recommended, because in this series it has led to no untoward results. Would any one pay the least attention to a similar contention claimed for chloroform from an experience of similarly few cases? The question is not if stovaine is a good anæsthetic for spinal cases, but whether or not it is the best. Here many thousands of cases have been operated on, and the results go to show that tropacocaine is as superior to stovaine as, in ordinary cases, when mortality figures are reckoned with, ether is to chloroform.

†This is important, as the ordinary canulas are plated only outside usually, leading to rusting inside the tube, with consequent risk of carrying particles into the spinal fluid.

treatment of mammary carcinoma the operation is very extensive and complete: the supraclavicular space is usually cleared out, and the axilla always. I may here draw attention to the excellent work which has been done by Dr. Finsterer, one of the chief assistants, in investigating the results of such operations, work which is insufficiently known in England, and which is undoubtedly among the most important that has been done in this important branch of surgery during the last few years. At great personal inconvenience and trouble ("I took no holidays for the three years," the doctor tells me, smilingly), Finsterer traced no less than 606 cases of mammary carcinoma which have been operated upon from the year 1876. The vast amount of labour entailed by this investigation may be realised when one finds that it necessitated extended correspondence, personal inquiry and examination by reliable practitioners, not only in the various Austrian provinces, but in Russia and Roumania and Germany as well. Out of these 606 cases, 492 were definitely followed up, while 114 could not be traced, or effectively considered for various reasons. The results of this investigation are full of interest. I have only space for a few notes, but the whole of Dr. Finsterer's work is so instructive that it demands to be read by every student interested in the treatment of mammary carcinoma. For further interesting particulars about age, etiology and other points, I must refer readers to the paper itself [*Ueber das Mammacarcinom und seine operativen Dauerheilung.* Leipsig, *F. Vogels Verlag.* 1907]. Finsterer finds that the percentage of cures by operation has been steadily rising since 1876–1881, when it was 4·7 per cent. At present (1896–1903) it is 24·64 per cent. By "cure" he understands, not as most German authorities take, with Volkmann, a three years' limit of freedom from disease, but at least four to five years, and, in view of the late recurrences he records, he is inclined to fix an even higher limit. In all, he has been able to record fully the 65 cases of permanent cure, the patients being alive and well 5—26 years after the operation. In these 65 cures the following statistics are interesting:—In 39 cases the skin was implicated; in 4 there was ulceration; in only 3 was the tumour firmly adherent to the great pectoral (from which he concludes that implication of the skin is relatively less bad in a prognostic sense than involvement of the pectoral); in 61 cases the axilla was cleared out; in 20 cases the supraclavicular fossa (in only 5 of these the histological examination could not detect carcinoma in the glands removed). He gives, in addition, the records in which at the operation carcinomatous supraclavicular and posterior triangle glands were removed, and which a subsequent autopsy showed that there were no internal metastases—an important point when the teaching that "supraclavicular metastases mean internal metastases" is borne in mind. Even more hopeful is the case of cure he records in a woman operated upon for extensive involvement of the skin (cancer en cuirasse). The patient is alive and well seven years after the operation. Even more than implication of the supraclavicular glands, cancer en cuirasse has been held as absolutely contra-indicating operation. It is true this is the only cure recorded in nine cases operated upon, but it is encouraging, and certainly supports Heidenhain's contention that in some rare cases metastases may undergo degeneration and so lead to cure. At any rate, Finsterer's statistics (which remind one of Dr. Karl Pearson's work, so thorough and painstaking they are, and so really valuable) demand attention, as they are the first attempt, so far as I know, to follow up a large number of cases, compare them on all points, and exhaust them from a statistical point of view. This is specially noticeable where this question of supraclavicular glandular involvement, where we met with none of these vague statements that are so irritating in Halsted's works but are given chapter and verse for every assertion. I have already shown that Finsterer is not content with the three years' limit, and he carefully excludes from his list of cures the cases of late recurrences. These last are very remarkable, for he records cases of recurrence, in his series of 606 cases, 10, 11, 13, 16 and 20 years after the primary operation, and equally interesting cases (which one must agree can scarcely be taken as recurrences), where many years after the primary operation the patients died of rectal, pyloric or colic carcinoma. The paper teems with interesting data (such as the cases of carcinoma during pregnancy and the so-called Volkmann's tumour mastitis carcinomatosa), and is an exhaustive analysis of the operative treatment in which the literature of preceding authors, English and American as well as Continental, is fully made use of. The main points laid stress upon are that (1) the percentage of "cures" is rising with more thorough operations, in which the extent of interference is decided by the extent of involvement; (2) that the operation, according to Halsted's method, appears to be the best; (3) that wide removal of the skin is necessary: (4) that the supraclavicular fossa should be cleared in all cases, and must be so cleared when there is the least sign of glandular involvement; (5) that the question whether extensive involvement of glands in this fossa means internal metastases or not cannot be decided as yet, but stands in need of further investigation, and finally (6) that on account of the frequency of late recurrences no case ought to be claimed as cured on a less short limit than five years. The latest figures, Dr. Finsterer tells me, in cases in which the skin has been more extensively removed, give a percentage of 33 cases past the five years' limit. In accordance with these conclusions, the operation for mammary carcinoma is very thorough. The only point one is inclined to carp at (as at Biers' clinic) is the great pains taken to remove the breast and glands in one piece. This attempt prolongs the operation, and it has yet to be proved to be necessary. The absurdity of removing the breast tissue with such care and then the supraclavicular glands piecemeal needs no comment. One hears it stated that "the cutting of a lymphatic may spread the cancer into adjacent parts," and other equally far-fetched statements, and one can only wonder how it is that these supporters of this

virulent infective theory do not bring conclusive evidence of their contentions. With regard to complications at the operation, Finsterer states that in 22 cases the axillary vein was resected; the artery in six cases. These ligatures led to no unpleasant result, and in five cases artery and vein were tied together without more than transient œdema and pallor being noticed in the arm. In two cases, such double ligature led to gangrene of the arm, necessitating amputation, which was followed by death by pneumonia. In three cases the subclavian artery and vein were ligatured simultaneously. No bad result followed these three cases.* Operations for recurrences were all unsuccessful, although they all prolonged life. Oophorectomy, first proposed by Schinzinger in 1889, and later carried out by Beatson, an operation which has several times been done at Guy's in cases of inoperable carcinoma mammæ, was not done in any of the 606 cases.

The student at Professor von Hacker's clinic will naturally feel most interested in the abdominal operations, seeing that the chief is one of the recognised authorities on intestinal surgery. A good many intestinal operations are done, both by the chief and by the assistants. Pylorectomies are done according to the modified Kocher's method, the results being very good. Gastrostomies are done under local anæsthesia by von Hacker's modification, in which the abdomen is opened in the middle line, and the stomach diverticulum made to emerge underneath the rectus, somewhat after a Frank. The patient is fed at once through the catheter. This method gives a good sphincter-like closure and patients seem very well satisfied. Rectal carcinomata (which seem frequent here) are excised very widely; in the female the Professor prefers the vaginal method, in the male the sacral or perineal. It is, of course, impossible to judge of results so soon after seeing the operation, but the Professor tells me that he regards the operation, when done early enough, as decidedly curative. Thus he has a private patient whom he operated upon more than sixteen years ago for carcinoma. This gentleman follows his occupation—that of a lawyer with a large practice—without any inconvenience, and reports himself yearly for examination. Equally good results are recorded by Hartmann of Paris and Kraske of Freiburg. Von Hacker does not do a preliminary colostomy in these cases, but the patients are very carefully prepared for operation, and the after-treatment is as carefully attended to. A great many œsophagoscopies and gastroscopies are done at the clinic, and the Professor is one of the most expert craftsmen with these new aids to diagnosis. He contents himself with cocainising the base of the tongue and the ventricle, and introduces the tube with its obturator so smartly that the patient scarcely seems to notice it. There is no struggling or retching, and the examination may be carried out quietly and calmly. Usually it is very methodical, every inch of the œsophagus being scrutinised. The more one has seen of this instrument, the better does one appreciate its diagnostic possibilities. The field, when the operation is properly carried out, is clearly visible, and the only difficulty is to interpret correctly what one sees. Growths are usually on the anterior wall; they appear as small knobs, with a depressed base, in the early stages. In later stages (when œsophagoscopy becomes increasingly difficult) it is, of course, easy to recognise the ulceration and extensive involvement of the wall. In one case the Professor noted certain unusual features in the œsophagoscopic picture of a relatively small tumour, low down, and pronounced in favour of a sarcoma—a diagnosis which turned out to be correct. This is the first case of primary œsophageal sarcoma (in itself a very rare lesion) successfully diagnosed, and the case will be fully published in due course. Very pronounced are the pictures seen in a case of foreign bodies impacted in the wall of the œsophagus, or of ulceration at the cardiac end. The surrounding mucosa appears as a white wall of circumvallation around the dull foreign body. In bronchoscopy equally fine views are obtained.

Of the interesting operations one sees at this clinic, I can only write briefly. First must be mentioned tracheoplasty, which von Hacker has done in several cases, with excellent results. The operation falls into several stages. First, a piece of rib cartilage is implanted subcutaneously in the neighbourhood of the trachea; when this has healed, in it is flattened and used to form the anterior wall to close the opening in the trachea. In another case the Professor shaved off a thin piece of cartilage from the thyroid and used this. A low tracheotomy is done as a preliminary, and the operation is completed under kelene (ethyl chloride) anæsthesia. I saw an interesting case of spinal tumour. The patient, a middle-aged man, was transferred from the neurological department with a diagnosis of tumour of the cord. Professor Hartmann, a very able diagnostician, located the tumour to a nicety, and expressed the opinion that it was a very vascular growth. He concluded this from the fact that injections of adrenalin very considerably modified the patient's symptoms. The localisation presented certain difficulties, owing to the irregular distribution of the anæsthesia, but a laminectomy was made, the seventh, eighth, and part of the sixth dorsal vertebræ being attacked, and the localisation proved to be perfectly accurate. The patient was in a very poor condition, with extensive decubitus, and by no means a good subject for operation. The laminæ were removed by means of chisel and bone forceps, and as soon as the canal was exposed it was clearly seen that there was a well-marked vascular tumour, intra-dural, compressing the cord below the sixth and seventh vertebræ. The spinal theca was opened, and the growth, which bled freely, and proved to be an angio-sarcoma with relatively little fibrous element in its composition, was removed piecemeal. The spinal dura was sewn up with thin silk, and the wound drained. The whole operation, which was

* Dr. Finsterer has just presented me with his latest statistical work, an exhaustive summary of extra-uterine pregnancy and its operative treatment, being the result of his observations on 133 cases. It is as thorough and painstaking as his work on mammary cancer and a very valuable contribution to the literature on this interesting subject. Both these works show what an enormous amount of material is available for special investigation at Austrian clinics.

brilliantly carried out by the Professor, was the quickest laminectomy I have seen, lasting barely forty minutes. After the operation the patient was very poorly, but he gradually gained ground, the first sign to be noticed that seemed to point to improvement being the fact that the patches of decubitus improved steadily. At present he declares himself to be "worlds better." The agonising paroxysmal pains from which he suffered before the operation have entirely disappeared, motion and sensibility are gradually returning, and he appears to be well on the way to recovery. The wound has given no trouble, notwithstanding the bad condition of the skin in the vicinity. For several days after the operation he had paralysis of his sphincters, but this complication, too, is gradually vanishing. This case was a brilliant illustration of the advantage of medical man and surgeon working in conjunction, and one does not know which to admire more, the operation so deftly and quickly executed, or the diagnosis so exactly and correctly made. Another interesting case of tumour of the cord was deemed to be inoperable, the localisation being high up in the cervical region, if not actually implicating the medulla. The operation in the first case was rendered so much easier by free use of the chisel. The statement that this is to be condemned, as it causes concussion of the cord, was not borne out in this case, and certainly when one has seen a surgeon literally fiddling about at the bottom of a deep narrow laminectomy wound with a Gigly's saw, or, worse still (as I saw in one case), with a small Doyen that proved unable to perform the work, one finds the chisel ever so much more satisfactory. The bleeding in this case, though free, ceased upon removal of the tumour, while there was very little escape of cerebro-spinal fluid. The angiosarcomata of the cord are second in frequence of cord tumours, the gliosarcomata standing first. Pure sarcomata are unknown, or must be very rare at all events, for there is, so far as I know, no undoubted record of a case, and German pathologists say that they have not met with it.

Another interesting case was that of a woman who had been several times operated upon for crural (femoral) hernia and came for a recurrence. The patient was operated on by Dr. Streissler, who performed a "sartorius plastic," suturing the proximal end of the divided sartorius muscle over the crural canal. The operation has not been done very often, but is stated to give excellent results, the contracting muscle, which is divided well below the entrance of its main arterial and nerve supply, acting as a firm pad over the dilated canal, and thus actively opposing the descent of the hernia. With the pectineus it is different. Only a relatively small piece of this muscle can be utilised for closing the canal. Its nutrition is by no means assured, and in the great majority of cases it shrinks and atrophies, and no longer acts as a block to the descent of the hernia. The new operation is difficult and tedious, especially in old cases operated on before, but it can, of course, be carried out under spinal anæsthesia. Dr. Streissler does a large amount of plastic bone work, all very interesting operations, and he has been good enough to show me some of his results. These latter are very good, in one case especially, where the lower half of the ulna has been removed for primary sarcoma and replaced by a graft taken from the patient's tibia. Not only are union and growth, as shown by the skiagraphs, good, but function is excellent, the operated forearm and wrist differing little from that on the sound side. Other cases in which these grafts were done are doubly interesting because they were cases of the so-called "Cystic disease of bone," to which Mikulicz paid so much attention. This condition is rare in England, though I believe there are one or two specimens in the London pathological museums (not in Guy's, however, where the seven specimens of bone cysts are all hydatids), but here it seems to occur more frequently. Whether this is a relative or real frequency I do not know, but I have had an opportunity of examining three cases in which the diagnosis of cystic disease was made and verified at operation. The condition is not unlike that seen in cases of hydatid disease of bone (as described by Mr. Targett in his paper in our Reports), but the name is unfortunate, as these excavations are not true cysts. They are not lined by a layer of epithelium, but are cavitations into the bony matrix itself, and their etiology is as yet quite obscure. They are certainly not similar to the rare cystic chondro-fibromata of the femur which occur usually just below the great trochanter in young patients. In this latter condition, which is clinically differentiated from endosteal sarcoma by (1) situation, being usually in the shaft; (2) very slow growth extending over years; (3) bending of the bone instead of spontaneous fracture as in sarcoma and hydatid disease; and (4) X-ray appearances, the cysts are multiple, lie in the bone marrow, are small, and when in an advanced stage, may thin the bone and produce crackling. Cystic disease usually occurs at the ends of the long bones and very probably has some relation to the epiphysial line, though it is nearly always found in the diaphysis, whereas in myeloid growth the epiphysis is almost always affected. The prognosis, when operation is done and bone transplantation used, is very favourable, although cases are recorded in which, after extirpation at one side, the disease has reappeared in another bone. Several cases have lately been operated on at the Graz clinic, and the specimens are very fine. The material for studying the condition is therefore rich enough to justify an extended investigation such as Dr. Streissler is now engaged upon.

I was especially interested in Dr. Streissler's cases of hip luxations, operatively treated. Although dislocation of the hip is said, by the text-books, to be fairly common, one does not see many cases of traumatic dislocations. At Guy's I have only seen two—one under Mr. Golding-Bird and a second under Mr. Dunn, both the sciatic variety. At Cologne one sees a good many, for that centre is undoubtedly the best place at which to study traumatic lesions of bones and joints, not only because the material is large, but because Professor Bardenheuer is one of the foremost authorities on fractures and dislocations. The operative treatment in old unreduced

dislocations is confined to open replacement (operative reduction), resection of the head, and osteotomy. With the open operation Streissler has had very good results in his cases of obturator dislocation. In one case, a boy operated upon five weeks after the injury, the result is perfect—no shortening, impairment of motion, or limitation of the usefulness of the joint being observable. In his very interesting account of this case, in which Dr. Streissler has gone minutely into the pathology of the lesion, he agrees with Bagardi that the new acetabulum which forms in such old unreduced hips is not the result of pressure atrophy, as is so usually stated, but is directly due to the regenerative activity of the pelvic periosteum. He operates according to Kocher's method (the lateral operation), in which the incision does not interfere with important muscles or nerves, and gives easy and free access to the head. Dr. Streissler also advocates the open method in congenital cases, in which, with his large experience and operative expertness, he has had brilliant results. I cannot, however, see what advantages such open interference, in the majority of cases, has over the easy, safe and as brilliantly successful bloodless reposition according to Paci or Lorenz's methods. There is always the danger of ankylosis, and whereas any practitioner ought to be able to treat a case successfully with the bloodless method, few will venture to attempt such a grave operation as freely laying open the joint and conquering the lesion at the point of a scalpel and bone forceps.

Graz, August, 1908. C. L. L.

Preparation Received.

"Soltabs."

We have received from Messrs. C. J. Hewlett & Son a sample of their "Soltabs," which is a patent name for compressed drugs intended to be made into solutions, thus distinguishing them from the ordinary compressed tablets designed for administration in solid form. "Soltabs" have a distinctive shape, similar to that of cachets, they are readily pulverized, and fairly easily dissolved. Various drugs, such as alum, borax, cocaine, eucaine, adrenalin and several nasal preparations are put up in this form, which provides a convenient means of storing drugs and of quickly making up solutions of a known strength.

Messrs. Hewlett also sent a sample of their compressed tablets of Glycerophosphat. Co. c. Hæmoglobin. These are suggested for use in anæmias, especially for "weakly, pale or too quickly growing children." These too, of course, are very convenient from the point of view of storage and accurate dosage, but we should imagine that these particular drugs are more efficaciously administered in fluid form, and it may be mentioned that Messrs. Hewlett also supply the Glycerophosphate preparations in this form.

Sport.

Rugby Football.

GUY'S HOSPITAL v. LONDON WELSH.

Played at Honor Oak Park on Saturday, Nov. 14th, before a fine crowd of spectators; the stand was also full, and many were turned away for lack of room. Play was most interesting throughout, as each side led in turn, and not until the last few minutes of the game did Stringer finally put his side on top. The Visitors brought down a good side and gave nothing away in the way of tackling, their methods being vigorous in the extreme, but the home side were equally thorough and, what is more, lasted rather better. The forwards were early prominent, and after a short period of footwork Mullins touched down in an easy position for Stokes to goal. The Welsh played up after this, and Harding, who played apparently in any position except full back, got on the move and ran well down the field, eventually passing to Maddocks, who, with a very tricky run, landed a fine try close by the goal posts, so that Harding had no difficulty in putting on the extra points. On resuming, Alexander for the visitors got away on the left wing, but could not pass Stringer, and at half time the scoring was level.

Weak defence on Medlock's part let the Welshmen up the field directly the second half was commenced, and a Guy's man getting offside, Harding had a shot at goal, but the kick was a poor one. The Welsh pressed for a time, till Glendining found touch by the stand: from the line out Stranach secured and made a lot of ground, but was pushed into touch. Guy's gained further by strong forward play, and only fine defence by Alderman kept them out. Not to be denied, Guy's tried passing, and the ball eventually reached Stokes, who hesitated and was bundled into touch; next Lacey, when well placed, over-ran his pass, but at length the ball came out to the Hospital right wing and Stringer, who was in good form, made two runs in quick succession, but no score resulted. At length Guy's was awarded a free kick for offside and Stokes kicked a very fine goal. The next interesting point was a touch-finding kick by Rowlands, following which Vivian passed to Maddocks who dropped a neat goal. One point to the bad the Hospital went "all out." The forwards were excellent, and rushing the ball down the field, established a footing in the Welsh territory, where Lee made a nice opening for Stringer, who putting on his best pace scored an unconverted try by the corner. The game thus ended: Guy's, 2 goals (1 penalty, 1 try), 12 points. Welsh, 2 goals (1 dropped), 9 points. Team:—

GUY'S.—G. Glendining (back); L. B. Stringer, H. Lee, G. C. W. Lacey, L. Stokes (three-quarters); J. G. Saner, A. H. Medlock (halves); H. R. Mullins, H. Archer, A. H. Crook, H. Hoby, W. S. Stranach, C. G. Sprague, A. Seabrooke, A. B. Danby (forwards).

REMARKS.—The forwards were excellent, especially with their feet. When near the line a little more handling, if done accurately and quickly, would conduce more to scoring. Saner has found, or rather re-found, his proper position, "scrum half." The "threes" were decidedly better, although sometimes standing too deep, that is, too far back from the scrum base, thereby making it easy for their attacking movements to be spoilt by effective marking. Glendining, especially for a first appearance, made a very creditable back.

Referee: Mr. Calver.

GUY'S HOSPITAL v. LONDON IRISH.

A good crowd, which, it is satisfactory to say, well patronised the stand, witnessed the above fixture at Honor Oak Park last Saturday. The hospital had a good side out, but Archer is a little out of place at three-quarter; it would be, however, distinctly unfair to criticise his performance in that position, considering the fact that he consented to fill it more to oblige than anything else, a little misunderstanding having arisen as to who should partner Lee at centre threequarter.

Early in the game Saner marked, wide out; Stokes took the kick and landed a splendid goal, having just previously missed a penalty goal at long range. Next Saner got away cleverly from a scrum on the right, and scored a try by the corner flag, Stokes' kick going wide of the posts. The Irishmen being 6 points in arrear, by very strenuous play got more of the game; but Stringer, who partnered Lee in the inside positions, brought off some fine tackling, and Lee also being at his best in this respect the Irishmen found it difficult indeed to press their temporary advantage home, until a loose dribble by the visiting pack, aided by O'Grady, saw the ball bounce awkwardly for Lacey to field, and O'Grady, dashing up, kicked over and reached the leather first; the same player kicked a magnificent goal, almost from the line. Shortly after this, Brydon, one of the visiting forwards, was hurt, and eventually retired for good, whilst another member of the Irish pack was reprimanded by the referee for not "playing the game." Lee was the first victim of this gentleman's unpleasant attentions, and, a little later, Crook. At half-time Guy's held the lead, but only by 1 point.

The home forwards went off with a rush as soon as play recommenced, Sprague being prominent; but Forster and Moran found touch with some good kicks, and Guy's had some difficulty in repelling an attack which ended with a series of scrums on the line. Finally Hind dribbled, and brought relief with a touch kick by the stand. Guy's now took charge of the game, controlled the scrums, and heeled quickly and well. Saner did the needful at the scrum base, and Stokes was sent away, but he lacked the needful resolution, and Pantlin easily collared him. Archer had the worst luck with two passes; Saner got to the line, to be tackled when all but over, and Medlock suffered the same fate. A drop-out was next fielded by Stringer, who made a glorious run, but his pass went a-begging; then, as a final wind-up, a fine handling bout enabled Stokes to score an unconverted try, leaving Guy's winners by 1 goal (from a mark) and 2 tries to 1 goal. Team:—

GUY'S.—G. E. W. Lacey (back); L. B. Stringer, H. Lee, H. Archer, L. Stokes (three-quarters); J. G. Saner, A. H. Medlock (halves); H. R. Mullins, G. R. Hind, W. E. Williams, A. H. Crook, H. Hoby, H. Stranach, G. C. Sprague, A. Seabrooke (forwards).

REMARKS.—Lacey was not quite so safe as usual, but still did much good work with his usual finish. The three-quarters suffered somewhat from Medlock passing wildly; in defence they were excellent, except Stokes, who will not, apparently, tackle "low." The same player would so much increase his reputation if he would run resolutely, exhibit some vim, use his pace and weight, and try to reach the line, no matter who or what the obstacles may be. Saner has not played better this season. The forwards were good, Mullins and Hoby followed up repeatedly and well. Williams made a welcome reappearance, and played one of his best games. All pushed hard in the tight, and once again there were no "passengers."

Referee: Mr. Sawyer.

GUY'S 2nd XV. v. ÆSCULAPIANS.

Played at Honor Oak Park on Wednesday, November 18th, and resulted in a win for the hospital by 26 points to 4 points.

The forwards were evenly matched, and it was the marked superiority of our halves and three-quarters that enabled us to win so comfortably, the play of Medlock, at half, and the combination between Covell and Sampson being especially good. The forwards were quite good in the loose, but packed badly. Irvine injured his knee, and had to retire about half-time. Our opponents' only score was a dropped goal in the second half. H. Sharpe kindly officiated with the whistle. Team:—

GUY'S.—H. J. Owen (back); B. Sampson, G. C. Covell, A. D. Williams, F. Tooth (three-quarters); C. H. Medlock, P. J. Monaghan (halves); V. Glendining, A Seabrooke, L. C. D. Irvine, H. Danby, L. Muir Smith, W. J. D. Smythe, R. Curnow, E. L. Elliott.

GUY'S 2nd XV. v. TONBRIDGE TOWN.

Played at Tonbridge on Saturday, November 21st, and resulted in a win for Guy's by 28 points to 3 after a fast and strenuous game. The forwards were very ragged in the first half, but were much better together in the latter part of the game. All the backs played well, especially Pritchard and Tooth, each of whom obtained very good tries in the second half. The first half was evenly contested, the half-time score being 13—0, but in the second half we had things more our own way, and only the sound tackling of Le May at back prevented the score being greater than it was. Pritchard, Tooth, Sampson, Danby, Stout and Covell scored tries. Team:—

GUY'S: H. L. Duke (back); B. Sampson, G. C. Covell, H. Mather, F. Tooth (three-quarters); L. C. W. Cane,

G. B. Pritchard (half-backs); T. D. Stout, V. Glendining, L. C. D. Irvine, W. J. D. Smythe, L. Muir Smith, H. Danby, R. Curnow, E. L. Elliott.

GUY'S 2nd XV. v. ROYAL VETERINARY COLLEGE.

Played at Honor Oak Park on Wednesday, November 25th, and resulted in a win for Guy's by 13—0.

Rather a weak side did duty for the second in consequence of a scratch game at Bedford. The game was throughout of a scrambling nature. The forwards, though outweighed, played pluckily. In the first half the only score was a try by Tooth, which was converted by Glendining. In the second half Tooth again scored, but this time the place kick was unsuccessful. In the last few minutes Duke scored a try from back and Glendining converted, Guy's winning as stated. Team:—

GUY'S.—H. J. Owen (back); H. L. Duke. G. C. Covell, H. Mather, F. Tooth (three-quarters); W. T. Clarke, F. C. Hunot (halves); V. Glendining, L. Muir Smith, W. J. D. Smythe, T. P. Cole, R. Curnow, A. Barraclough, J. L. Stewart, A. C. Hancock (forwards).

Association Football.

SURREY JUNIOR CUP.

On November 21st Guy's "A" met London County Banks "A" at Honor Oak Park. The game was very uneven, and Guy's won easily by 5—0, thus qualifying to meet Alleyn "A" in the 3rd Round.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

W. L. W. M., HUDDERSFIELD.—These fragments from the cervix uteri are infiltrated by a malignant growth. It is a columnar-celled carcinoma such as would arise from the glands of the cervix or body of the uterus.

H. L., MANCHESTER.—These two specimens are infiltrated by a malignant growth. That in the cæcum is composed of solid masses of epithelial cells, whilst that in the omentum is more tubular in type. It is, no doubt, a columnar-celled carcinoma in which the cæcal growth has undergone great epithelial proliferation.

G. M. J., ALTON.—No tubercle bacilli are detected in this specimen, which contains a little muco-pus.

PATHOLOGIST.

Change of Address.

H. I. JANMAHOMED, M.B., B.S. Lond., from the College, Guy's Hospital, to 29, Kirkstall Road, Streatham Hill, S.W.

M. D. PRICE, M.R.C.S. Eng., L.R.C.P. Lond., from Guy's Hospital to c/o H.B.M. Consul, Busrah, Persian Gulf.

F. A. SHARPE, M.B., B.S. Lond., from Monsall Hospital, Manchester, to the Health Office, Derby.

LOUIS STAMM, M.D. Lond., from 64, High Road, Streatham, S.W., to 43, High Road, Streatham, S.W.

E. CLARKE COHEN, M.D., M.R.C.S., from Fernleigh, Coulsdon, Surrey, to Fernbank, Shoot-up-Hill, Brondesbury, N.W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated.*

Marriage.

KIRKMAN—CHANTLER.—On October 8th, 1908, at the Parish Church, Plumstead, near Cape Town, by the Rev. Langford-Browne assisted by the Rev. F. Shermerdine, Albert H. B. Kirkman, F.R.C.S. Ed., L.R.C.P. Lond., son of the late Dr. W. P. Kirkman, M.D., late Superintendent Kent County Asylum, Maidstone, to Mary Louise Chantler, daughter of C. S. Chantler, Esq., of Barkside, London, and Leigh-on Sea, Essex.

Death.

MASON.—On November 12th, Sydney Herbert Mason, M.R.C.S., L.R.C.P. Lond., aged 35 years, formerly of 333, Moss Lane East, Manchester, only son of John Mason, The Rowans, Knowle, Warwickshire.

EDS.—L. M. & A. N. C.

GUY'S HOSPITAL GAZETTE.

VOL. XXII., No. 534.] DECEMBER 12, 1908. [SIXPENCE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

December.

Sat. 12. 1st XV. v. Richmond (Away).
2nd XV. v. Harlequins "A" (Home).
1st XI. v. Beckenham (Away).
2nd XI. v. Beckenham "A" (Home).
Physical Society, Clinical Meeting, 8 p.m. (President: W. W. Cook).

Mon. 14. Clinical Lecture by Dr. Hertz (Electro-therapeutics), 1.15 p.m.
Cambridge First and Second Examinations, and Part I. of the Third Examination for M.B. degree begin.

Tues. 15. Guy's Hospital Musical Society: Concert. Governor's Court Room, 8 p.m.

Wed. 16. 1st XV. v. London Welsh (Away).

Thur. 17. Messrs. Dunn and Rowlands' Take-in (Messrs. Hinde and Perkins).

Sat. 19. First half of Winter Session ends.
1st XV. v. Bedford (Home).
2nd XI. v. Kenley (Home).

Thur. 24. Sir Alfred Fripp and Mr. Turner's Take-in (Messrs. Syms and Price).

Fri. 25. Christmas Day.

Passim.

THE next issue of the GAZETTE, dated December 26th, will, on account of the Christmas holidays, be published on Wednesday, December 23rd. All contributions intended for this issue should therefore reach us on or before the preceding Saturday, December 19th.

THE pen-and-ink sketch of the late Sir Thomas Stevenson, which will be found as an inset, originally appeared, soon after the death of our distinguished toxicologist, in one of the evening papers. The original drawing is now in the possession of Dr. H. J. Spon, of Southwark Bridge Road, a former editor of this journal, who has kindly allowed us to reproduce the sketch for the benefit of GAZETTE readers.

MANY congratulations to the three Guy's men who, in the recent B.Sc. Examination at London University, obtained First Class Honours in Physiology. Messrs. Cook, Schlesinger and Todd have scored a success, of which both they and their school may well be proud.

THE Musical Society will give a concert on Tuesday next, December 15th, at 8 p.m., in the Governors' Court Room, under the direction of Mr. Henry Taylor. The principal works which are announced for performance are "The Erl-King's Daughter" (*Gade*), and "Song of Night" (*Schumann*); the rest of the programme will consist of vocal and instrumental solos, and part songs. We are asked to state that tickets, price 2s. 6d. each, for this concert, which is the first given by the Society this season, may be obtained from the Honorary Secretary, Mr. Douglas Mitchell, or from any of the Committee.

A SCENE of more than the usual interest and enthusiasm was witnessed during Dr. Pembrey's lecture on Monday last. Half-way through the time, the lecturer gave place to Colonel James, R.A.M.C., of the War Office, who came to explain the aims and objects of the Officers' Training Corps, and to receive the names of

Guy's men wishing to join the corps. The main features of the scheme have already been outlined in the Gazette, so that it is unnecessary here to do more than refer to some of its chief points as they affect medical students in general and Guy's men in particular.

An important feature of the scheme, and one which will appeal to all students, is that the course of training provided by the corps involves no expense whatever to the man who goes through it. Moreover, the completion of the two years' training leaves the cadet quite free to abandon all military duties should he prefer to do so; but, on the other hand, he can join the Territorial Army with the rank of captain, or the Special Reserve of Officers with certain privileges, or if he should desire to enter the Royal Army Medical Corps, he would receive 2% of marks in his entrance examination by virtue of his certificates gained in connection with the Officers' Training Corps. But even if he does none of these things, and spends the rest of his life in civil practice, the experience gained of emergency work and administration of hospitals in all their departments, as Colonel James pointed out, cannot but be of use to him. There is no need in this place to talk of the duties of patriotism, especially as we have but little faith in the patriotism which is merely a duty. We believe that the experience gained in meeting any contingency that may arise, the exercise, and the practice in shooting afforded by such a training as this, will have far more weight in persuading men to join than any abstract flatulent notions of patriotism. And, after all, if the main object —of providing a sufficient supply of thoroughly competent officers to command the Army in peace or war— be achieved, it matters little what has been the inducement to men in joining.

At the meeting on Monday, when Colonel James had concluded his address, the names of those wishing to join the corps were asked for, and we understand that some thirty-eight men signed on. An important concession, to the effect that the necessary lectures might be held at the hospital, was granted by Colonel James. At present our contingent will belong to the London University Corps, but should the latter reach ninety in strength, we might then form a separate unit, provided we could raise a minimum of thirty members. For the benefit of those (including most of the senior men) who were not at the meeting, we may add that a list has been posted up in the Smoke Room to receive the names of new volunteers, or names may be sent direct to Mr. Davies-Colley, who will supply any further information desired.

Mr. Croucher has forwarded us an acknowledgment of a further contribution to the Miller Fund, and asks us to state that he is still open to receive subscriptions to this fund for the support of an old and tried Club servant in his declining years. Mr. Croucher is anxious to increase the weekly allowance from 5s. to 7s. 6d., so that the old man may manage to keep going without the necessity of obtaining out-door relief, which during the present year he has been compelled to seek. He has in this way unfortunately disqualified himself for obtaining an Old Age Pension under the new Act, during the coming year. There must be many old Guy's men who remember old Miller, and will be glad to help the fund. Their contributions should be sent to Mr. Croucher at the Medical School Office, and will be duly acknowledged in these columns.

The conventional words and phrases used in describing diseases have on various occasions provided material for writers of "Lighter Vein." Love, for instance, has been dealt with in this way, and "side;" but so far as we are aware Christmas has not yet been similarly treated, yet it offers scope for a further excursion along a well-worn path. The symptoms and physical signs of approaching Christmas are now rapidly developing in our midst. Christmas is, of course, a condition marked by the growth of masses of new tissue (paper) and recent vegetations in the wards. Before the outbreak of this, however, there is some fever and restlessness. The physical signs are pathognomic: in spite of a distinct thrill, there is no dulness anywhere; on the contrary, a definite Christmas-boxy note can be detected all round. The coin sound is also well marked, and its disappearance

is a grave sign and should suggest a guarded prognosis. Loud musical bruits are only too plainly audible, especially in the College area. Sometimes these are more suggestive of the *bruit de pot fêlé*. There is no treatment for the disease other than symptomatic, and it must be allowed to run its course, which, under normal conditions, it does in eight days from the time of onset.

To turn from fancy to fact, we are able to announce that on December 26th, 28th and 29th the President of the Residents will present a topical farce entitled, "The Dean's Dilemma," or "The Sister, the Socialist, and the Statue," which will be preceded at 8.15 by a curtain raiser by Gerald du Maurier and S. O. N. Frere, entitled "Charles I. and Charles II." It is whispered that Mr. Brookhouse has again done himself justice in the farce, and that Mdlle. Julia Caroli and party have again kindly consented to give a concert between the plays. Application for tickets should be made to—The Business Manager for the Residents' Theatricals, The College, and must reach him not later than December 18th.

Another curious and amusing letter has been sent to us. In our last number we gave an example of amateur pathology; the present letter, which was written by a Kaffir in reference to the illness of his wife, is an example of amateur description of symptoms, and provides a "case for diagnosis." It is comparable, in fact, to the "H.P.D." of the medical reports, and if it cannot be commended to the ward-clerk as a model for grammar or accuracy of description, it has something to recommend it in simplicity of style:—

> "I want a bottle of medicene for a sick person. I want to explain her complaints in her body:—She is Head-ache: she is eight months without her womanly-nature, she coughs, she feels a shooting pain right through her chest to the back. She can hardly breathe. She is greatly suffering from the pains of her waist. Her body shakes. Her feet and legs are warm as if they are on a hot pan. She is stomach-ache. She cannot blow out naturally. Her noses are very stiff. Her knees are very sore."

We are, unfortunately, not informed as to the diagnosis made, or the treatment prescribed.

We hear that Capt. R. G. Anderson, R.A.M.C., has been appointed a member of the Sudan Sleeping Sickness Commission, and is proceeding to the Bahr-el-Ghazal for the investigation of this disease.

So far as the general practitioner may be said to have a "cause" distinct from that of the profession as a whole, Dr. William Alfred Elliston, of Ipswich, who died on November 27th, was one of the strongest and most respected champions of that cause. Born in 1840, he came of a race of doctors, and he continued the family tradition by entering as a student at Guy's after his preliminary apprenticeship to an uncle. His father's ill-health necessitated his leaving the hospital as soon as his course was completed, and, having taken the diplomas of M.R.C.S. and L.S.A. in 1862, and graduated M.D. of St. Andrew's in the same year, he went home to carry on the family practice. He held in due course various public appointments, including the post of surgeon to the East Suffolk and Ipswich Hospital, and in addition he was an active member for some years, in the interests of progress, on the Borough Council of his native town, and later was a J.P. for the County of Suffolk. He took a prominent part in the prolonged and abortive agitation to secure for members of the Royal College of Surgeons a share in its constitution. He was also active in the interests of the British Medical Association, and became its President in 1900, during which year the annual meeting was held at Ipswich, and was for some time President of the Medical Defence Union, in whose valuable work he was keenly interested. Dr. Elliston thus combined with a busy hospital and private practice multifarious activities in other directions, and his loss will, therefore, be deeply felt, not only in Ipswich, but in the whole of East Anglia, and in the various organisations with which he was connected.

Miller Fund.

Dr. F. K. Butt	...	...	...	...	£1	0	0

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

A Catechism on the Urine.

DEAR SIR,—In view of the difficulties sometimes experienced by medical students in applying their book-knowledge about urines, when they are asked examination questions that are not straight out of the book, I should like to draw attention to some interesting articles upon the subject that have appeared in the *Dublin Journal of Medical Science* this year. That Journal is to be obtained in the Wills Library.

The following Urinary Catechism cannot but be of interest to all. It is to be found, together with explanatory notes, in a paper by Walter G. Smith, M.D., Physician to Sir Patrick Dun's Hospital, on page 323 of the Journal referred to. As the author states, it "embraces most of the ordinary points with which every student and practitioner should be familiar." It would be excellent practice for every student to think out the answers to the catechism questions for himself. It is the thinking of them out that will be so valuable to him; to have the answers given to him would be to destroy a great part of their value.

URINARY CATECHISM.

1. What is the nature of the precipitate produced by adding a few drops of liquor potassæ and liquor ammoniæ, respectively, to urine?

2. What will happen when urine is treated with a few drops of HCl, and allowed to stand?

3. What is the nature of the precipitates afforded by adding to urine, respectively—
   i. Ag NO_3;
   ii. Lead lotion;
   iii. Liquor ferri perchloridi?

4. How would you test urine for:—
   a. Chlorides;
   b. Sulphates;
   c. Phosphates;
   d. Carbonates;
   e. Uric acid in solution?

5. What urinary sediment alone is redissolved upon warming? What inorganic salts may be thrown down upon boiling urine?

6. What is the composition of:—
   a. White gravel;
   b. Red gravel, or red sand;
   c. Mulberry calculus?

7. What are the causes of the usually acid reaction of normal urine?

8. Why is normal urine sometimes neutral, or alkaline, in relation to litmus? Why is it sometimes amphoteric?

9. How would you distinguish between a phosphatic and an albuminous precipitate produced by heat alone?

10. How would you identify a calculus consisting of or including calcium oxalate?

11. What inorganic salts never occur in sediments or calculi? Why?

12. What is the commonest and most voluminous inorganic deposit from urine? What is the effect of treating it with liquor potassæ or liquor sodæ?

13. What acid is often deposited in the free state from urine? What would be the effect of treating this deposit with liquor potassæ? In what form does most of the uric acid occur in urine?

14. What salts of the alkali metals are never found in urinary sediments, and why?

15. What is the chemical nature of the more common urinary calculi and concretions? What is the most insoluble salt met with in urine?

16. Give a simple scheme for the qualitative analysis of urinary calculi.

17. What free acid radical occurs in solution in urine?

18. How may it affect the solubility of certain salts?

19. What deposits are liable to form, respectively, in;—
   a. Highly acid urine;
   b. Alkaline urine (fixed alkali);
   c. Alkaline urine (ammonia, volatile alkali)?

20. What is the average amount excreted daily of:—
   i. Urea;
   ii. Chlorides;
   iii. Phosphates?

21. What is Offer's colour test for uric acid in solution?

22. Which of the acid radicals in the urine arise:—
   a. Chiefly from the food directly (exogenous);
   b. Chiefly from chemical processes within the body (endogenous)?

23. Which of the urinary salts may cause turbidity:—
   a. In warm freshly-passed urine;
   b. In urine which has cooled, or stood for a time?

24. What salt may be deposited, whether the urine be acid, neutral, or alkaline in reaction?

25. Which of the urinary sediments are readily dissolved by:—
   a. Dilute acids;
   b. Solutions of alkalies?

26. What may be the nature of the iridescent film sometimes observed on the surface of the urine?

27. Under what circumstances may a mixed precipitate of urates and phosphates arise?

28. What is the nature of the white precipitate observed when strong alcohol is floated on normal urine?

It will be noted that the above catechism applies to normal urines. If it were not for occupying too much of your valuable space it would be interesting to give a similar catechism for abnormal urines.—I am, dear Sir, yours faithfully,

HERBERT FRENCH.

Presentation to Mr. Turner.

DEAR SIR,—May I, through the columns of the GAZETTE, express my heartiest thanks to those Guy's men who have worked in the Dissecting Room during the past five years, for their most acceptable gift on my retirement from the post of Demonstrator of Anatomy.

As it is impossible for me to see and thank each one personally, I trust that this acknowledgment may be seen by them all.—I am, Sir, yours faithfully,

PHILIP TURNER.

Two Prescriptions.

DEAR SIR,—Whilst on a visit lately to a cathedral city in the West of England, I saw a copy of a Cookery Book, the recipes contained in it being supplied by various members and friends of a church there, who were having a bazaar, the book being on sale at the various stalls. On glancing through it, I was struck with two of the recipes, which may perhaps be of use to some of your readers.—*Yours faithfully*,

Chadwell Heath. T. R. ATKINSON.

A LUNG AND CHEST TONIC.

Put nine new-laid eggs, whole—(washed clean) (?inside or out?)—into a pie dish, and pour over them the juice of seven lemons; let them soak for three days, turning each morning. Strain through a fine hair sieve, and wash the refuse (*sic*) with a gill of old rum or brandy. Add three-quarters of a pound of brown sugar and bottle *it*. Keep it well-corked and it will keep for a long time. (If never used?)

Dose—A wineglassful in the morning fasting. This mixture is a great help in consumption.

A COUGH MIXTURE.

Quarter pound lump sugar, 2 ounces of brown sugar of candy, 1d. cochineal, salts of tartar sufficient to be placed on a sixpence, 1 pint of boiling water to be poured over the whole.

(Wherein lies the virtue?)

Change of Address.

Chas. W. Greene, M.B., B.C. Camb., from the General Infirmary, Gloucester, to the Miller Hospital, Greenwich, S.E.

Alfred C. Jordan, M.D. Camb., from Leadenhall House, E.C., to 14, Weymouth Street, Portland Place, W. Telephone 3485 Mayfair.

W. Grant Oliver, L.D.S., from Guy's Hospital, to the Royal Naval Barracks, Devonport.

H. S. Pugh, L.D.S., from Guy's Hospital, to 71, Stanford Avenue, Brighton.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Notes from Rome.

BY FREDERIC VICARS, M.D., BRUX.

III.

A Winter in Rome.

I spent last winter in Rome. I don't suppose I shall ever spend another in the Eternal City, but the charm and interest of that visit will ever remain with me as a delightful memory. I have already in the GAZETTE described the climate, and personally I had nothing to complain of in that respect as far as the winter was concerned, but I have a vivid recollection of a return visit of one night in May, when I felt as if I had suddenly plunged into a breathless atmosphere, and rejoiced greatly on escaping next day by an early train.

To the tourist, a visit to Rome usually means a rush round the principal sights, finishing up with a severe chill, which he is terrified into considering "Roman Fever." We did not rush round the sights, and we did not get "Roman Fever."

I think what impresses one most in Rome is one's own ignorance. At first it is almost blighting, but gradually, as one jostles along in the footprints of history, touching the very stones of world-famed buildings, and gazing daily on places and things that one tilted against in the school-books; gradually, I say, one loses this impression, and is apt to think knowledge is easily and quickly obtained. The American professes to suck in Rome in a few days, I remember one queer fellow after a week's sojourn, saying: "Why, I am simply inflated with wisdom. I cannot talk to any ignorant person now!" He showed me a list of places he had seen. I asked him if he had been to the Sistine chapel. "Is it on the list?" he queried. "Yes." "Wall, then, I guess I've seen it," was his reply. He raced about Rome in a motor-car, and polished off his "sights" on his list, ticking them off with a pencil as he went round. The grandest sight in Rome, to my mind, is the Colosseum. We saw it often in daylight; but once visited it by moonlight, and as we stood in the vast auditorium, which looked like a gigantic honeycomb, we tried to meditate on martyrs, gladiators and wild beasts, but it was useless. Some frivolous spirit possessed us, and we found ourselves cracking up-to-date jokes about pickpockets and robbers in aggressively modern suits. We joined the Archæological Society in the hope of acquiring information in a condensed form at the meetings. All I remember of those meetings now is, that it was mighty hard to get a nap there, as the seats were decidedly uncomfortable! Matters archæological will always be associated with the huge gaps made in the ancient walls of Rome at the request of two English ladies, who found it convenient to have openings in the immediate vicinity of their houses. The Archæologists yelled, but the gallant Roman Municipality had their way, and the two ladies rejoiced in the advantages of a "short cut." Apart from the "sights," a considerable time is consumed in Rome by attendance at

innumerable teas. People flock to them like bees to flowers. The English and Americans, of course, predominate, but there is always a sprinkling of blue-blooded penniless Italians in search of heiresses, who are supposed to abound among the travelling folk. The Roman tea is an institution that will never die, and it is about all there is in the way of hospitality among the English residents. "I have asked them to tea," says an English matron, as though she was shadowing forth visions of a banquet. And they come to tea, and again to tea, and to other teas, and in their turn ask to tea, and to more teas. Thus the time passes.

But there are superior memories of Rome. One such was an audience with the Pope. There is no difficulty about seeing the Holy Father now. Application in the proper quarter will insure a "permesso." Pius X. loves to see his fellow-man, and nearly every day there are many audiences. Punctually at the hour we appear before the "Bronze door," where the famous Swiss guards are hanging about in their quaint uniform, looking remarkably like court cards. We are directed to a door within on the the right, and then commence a long climb up innumerable stairs, through a courtyard where more quaint guards motion us towards another door, and onwards and upwards by more stairs we mount, till at last we reach a large vestibule. Servants in crimson brocade take coats and hats, and usher us into a magnificent long room. The walls are covered with crimson brocade, like the flunkeys. At one end on a dais is a large gilt chair, while right and left of the dais are long benches against the walls We quickly find places among the people already present. To be correctly attired for an audience, evening dress is the garb for men; while black without ornaments, and with a veil, is *de rigueur* for women. Nowadays, however, men appear in apparently any sort of clothes. I note a pimply man, of vague nationality, in a coloured suit, a coloured shirt, a large gaudy tie and brown boots!—a symbol of modern democracy. Next me sits a friar in brown habit telling his beads. Ladies wait silently on the benches holding bunches of rosaries for the Holy Father to bless. One can hear the "click" of the beads as they fidget with them. Looking round, however, one is struck with the absence of any sign of emotion. The friar yawns. Doubtless he has been here before. Lackeys peer into the room from time to time. A man in black velvet court dress appears, looks at us all critically and then retires. We are getting fidgetty. Suddenly two crimson-clad servants enter, and sign to us to come. We pass out, and enter another beautiful chamber decorated in green brocade. Here we are requested to arrange ourselves around the room. Two apparitions in gorgeous uniforms now swagger in, uneasily conscious of their sham military appearance. A courtier in black velvet hangs about a door on our right. Eyes are directed there. More fidgetting. A lady says she has lost a cross. This produces a sort of "general post," resulting in the finding of the article. I tried to feel suitably impressed with my surroundings, but the man in the democratic garb looms ever in my eye and disturbs my thoughts. Suddenly the officer in black velvet darts forward and motions us to kneel. We all do so instantly, while every eye turns towards the entrance. A white figure appears. It is the Pope. From my position I can see him well as he moves slowly round the circle of kneeling men and women. He is clad in a long white cassock of fine cloth, with a little cape resting upon his shoulders. On his head is a small white skull cap; his shoes are red, and creak as he walks. He speaks no word as he moves. He passes along mechanically, with his right hand extended. Each one in turn kisses the magnificent emerald ring he wears. The Pope passes the strange garbed man like the others, without varying his pace or manner. His head is bent upon his chest. He is a big man with broad shoulders and a large pendulous belly; the latter tilts up his long cassock in front and shows his red shoes. He moves along, and now turns the angle at the corner opposite—the circle has ceased to exist. It is a kindly tired face that looks down upon each kneeling figure. There is almost silence in the room. Suddenly, as His Holiness stands before an aged woman, he snaps out some words in Italian. His voice is loud and querulous. Two crimson attendants rush forward with a dramatic lifting of the hands. A thrill of excitement passes through us. Again the Pope speaks. "Wow, wow, wow," comes from the old woman. Again the querulous voice speaks in loud tones. "Wow, wow, wow," again splutters the aged dame. "What is it?" I ask my neighbour, who rapidly explains that His Holiness is asking why she does not kiss his ring. There appears then to be some further comment by the Pope, to the effect that, if the lady does not kiss his ring, she will not get his blessing. Then something is said which apparently explains matters, and His Holiness passes on with a genial smile upon his face. His beautiful grey eyes have a twinkle in them, which certainly means forgiveness. When the round is complete, the Pope, standing near the door, gives his blessing in Latin, raising his hand the while. The kneeling people hold up various trinkets during the recitation. Some have their arms laden with hanging rosaries; some hold trays with crosses and little statues; others merely extend their hands with one precious article that is to be made more precious for the future. As he came, so he goes, suddenly. The white figure seems to vanish from our midst.

On our way down the stairs we overtake the old lady who created the scene with His Holiness. She is leaning on the arm of a young woman. She looks up plaintively, and I eye her with interest. At the first glance the mystery is explained! She has a very long hooked nose, a protruding chin, and receding lips due to edentulous jaws! The poor old soul *could not* kiss the Pope's ring!

There are several English and American doctors practising in Rome. I swelled their ranks for a brief time. Guy's now is happily represented by Dr. Donald Smallpiece, formerly of London. Rome offers little scope for practice, as competition is keen and goes on

increasing every year. The result will probably be that fees will soon be as low as those of the Italian doctors.

There is much more to be told of a winter in Rome, but I have already trespassed too much on the GAZETTE'S valuable space. In conclusion, let me advise every reader who has not been to Rome to make up his mind to go there sometime in his life. He will not be disappointed, and he will never regret the time spent in the Eternal City.

Guy's Hospital Debating Society.

"THE PURSUIT OF SCIENCE AND APPRECIATION OF ART."

THE 88th meeting of the Society was held in the College Smoke Room on December 5th, Mr. A. W. Ormond in the chair; 43 members were present. After the minutes of the last meeting had been read and confirmed, and some private business transacted.

Mr. HIBBERT moved, "That this House believes that the pursuit of Science diminishes one's appreciation of Art." After stating that he would not attempt to define Art, the speaker proceeded to draw a contrast between Art and Science, though he pointed out that in some cases, *e.g.*, photography, they overlapped so much as to be inseparable. Art appealed to the eye, the ear, the æsthetic sense; Science could not do these things, but appealed to the intelligence. On the other hand, Science sought wholly for causes; Art was concerned wholly with effects. The pursuit of Science gave essentially useful and practical results—huge engineering works, for instance, and health in place of disease. These practical results were better and deeper ends to have in view than the mere cult of beauty, and the pursuit of them, while it would not destroy, would certainly lessen, one's appreciation of Art.

Mr. BENNETT opposed. The wording of the motion, he said, implied that there was in one some pre-existent appreciation of Art, otherwise it could not be diminished. But we must not overlook the existence of the Philistines, who would probably support the motion *en bloc*. Disregarding the standpoint of the Philistines, there were probably two lines of argument which would be taken up by supporters of the motion:—(1) That the pursuit of Science leaves one no time for the cultivation of Art, and (2) that the pursuit of Science actually diminishes one's faculty for appreciating Art. As regards the first, there was no doubt that the student of Science had many leisure intervals in which to pursue Art, and so get the sensation of a *gourmet* who had been exiled in Tibet, on re-entering Romano's. Unlike the hon. proposer, Mr. Bennett ventured on a definition:—"Art is the expression of an emotion or an idea." Accepting this, it became plain that there were three ways in which Science could help one to appreciate Art, viz., it quickened the senses, it increased one's knowledge of methods of expression, and it enabled one to weigh one's emotions more accurately. It was true some scientists died of septic poisoning, and their appreciation of Art was thereby permanently impaired; but disregarding extreme cases, it might be said that the more a man knew of Science, the better could he appreciate methods of expression. As an instance, the speaker mentioned the work of the French impressionists, at first misjudged by the public and fellow-artists alike, and afterwards recognised at its worth entirely through the spread of a knowledge of the science of light among critics. Discussion was not to be limited to the medical sciences, but as a matter of fact they alone could prove the case for the opposition; a knowledge of anatomy, for example, improved one's appreciation of modelling; a knowledge of pathology gave one an added interest in the normal. Mr. Bennett said he would leave the discussion of music to others, but in the case of literature it was certain that a scientific understanding enabled one far better to appreciate some writers of the modern school, such as Ibsen, Brieux, and de Maupassant.

Mr. WEBB seconded the motion, and complained that the opposer had laid down certain lines of argument of his own, and then refuted them; and, moreover, had attempted a definition of Art. In view of the many definitions of Art which were current, why should we accept the hon. opposer's? Mr. Webb took up his standpoint on the basis that Art was the cultivation of beauty, and that, according to Goethe, "The ideal of beauty is simplicity and repose." The pursuit of Science was antagonistic both to simplicity—for it made complexities more complex— and to repose. A knowledge of anatomy led one to criticise detail, *e.g.*, to inspect the insertion of the trapezius in a statue, and so lose the general effect which Art strove to produce. Again, anyone with a knowledge of hygiene could look at a house only from the drainage point of view. Above all, as one saw in "Andrea del Sarto," Art concerned the uplifting of the soul; Science dragged it down into a slough of materialism.

Mr. SCOTT, seconding the opposition, said that hon. members on the other side of the House had attempted to prove at great length that Science and Art were foreign to one another, and then supposed they had proved their case. But one of them had been kind enough to declare that he had nothing to say against Art, the other that he had nothing to say against Science. It had been said that Art appealed only to the senses, but that was not the case; it appealed to Mind *viâ* the senses. Then every Art had its corresponding Science: the "builder of bridges," the physician, the musician, must all pursue both the science and the art of their callings. Whereas Darwin was the only name which could be cited in support of the motion, many could be cited against—Omar Khayyam, Pascal, and Oliver Wendell Holmes, for example. The spread of Science had killed the Romanticist movement, and generated a newer and a truer literature.

The CHAIRMAN then threw the subject open to discussion.

Mr. GARDINER said it had been assumed that the pursuit of Science was simply the amassing of *facts;* but it was more—it was the cultivation of the analytical faculty. One could, no doubt, appreciate music without a knowledge of science, but the appreciation was aided by the cultivation of that analytical faculty which Science gave. In listening to a symphony, for example, there were distinct stages in appreciation; one man might simply receive a confused sensation of sound; to another, a sense of rhythm was added; and a third, possessing the analytical faculty, would notice and appreciate the structure of the work. As with music, so with all arts, Science helped one in appreciation. Given but a small appreciation of Art to start with, as in the cases of Darwin and of Langham in "Robert Elsmere," perhaps the pursuit of Science might diminish it: but isolated examples such as these must not influence one in considering the motion which clearly attempted to lay down a general principle.

Mr. D. SCOTT instanced "Pachiarotto" and the "Ring and the Book" as cases against the motion. Science and Art, he said, were not antagonistic. Each of them gave a deeper insight into Life.

Mr. SCHLESINGER thought a distinction should be made between the "appreciation" of Art and the "understanding" of it. Added understanding did not necessarily bring added appreciation. An anatomist looking at Rembrandt's "Anatomy" overlooked the faces in the picture on account of his absorbing interest in the dissected arm.

Mr. LAYTON pointed out that the seconder of the motion had taken the trouble to explain that he appreciated Art, but had forgotten to add whether he had ever pursued Science. The instance of the Rembrandt—and incidentally the speaker was glad to find members accepted anatomy as a science—was not apposite: the anatomist's appreciation of the faces was not one whit diminished by his interest in the dissection. Furthermore, his knowledge might enable him to see false art where others thought they saw true. Again, a knowledge of hygiene need not destroy one's appreciation of old (and unhygienic) buildings, erected before hygiene was recognised as a necessity. Such buildings—erected to-day—would not be considered Art; similarly, a buttress was artistic only when it was also useful.

Mr. O'CALLAGHAN showed how the advances made in Art by the Greeks on the early Egyptians, and by the medieval Italians on the Greeks, had all been due to corresponding advances in scientific knowledge.

Mr. RECKITT stated that in one direction, at any rate, a knowledge of anatomy had increased his own appreciation of Art.

Mr. BURCH thought there could only be very poor appreciation without understanding. Art and Science undoubtedly overlapped, and without *technique* Art could do nothing.

Mr. PASSEY pertinently inquired why, if the motion were true, anatomy and the chemistry of pigments should be taught at the Royal Academy Schools.

Mr. MULLALLY said that a thing was not necessarily inartistic because it was incorrect. The case mentioned by a previous speaker, where a knowledge of anatomy had shown a defect in a statue, proved that Science did diminish one's appreciation.

Mr. REEVE said that lack of time had been mentioned as a cause of diminished appreciation of Art by those who pursued Science, but everyone had at least a few hours' daily leisure in which it was not only a relaxation, but a pleasure, to pursue Art.

Mr. GODDINGS supported the motion. Listening to music with understanding led to finding faults, and so to diminished appreciation.

Mr. OLLIS thought that the average man should be considered, and not Darwin: the former did not create his own environment; the exceptionally gifted did.

Mr. BILLING enlarged on "Murder as a Fine Art," which he thought had gained more appreciation through the spread of Science.

The SENIOR SECRETARY could not see the application of the quotation from Goethe which had been used. The instance of Goethe was peculiarly inappropriate, since he had been one of the most illustrious artists who had also successfully pursued Science.

Mr. BENNETT, replying for the opposition, said that the debate had followed remarkably closely on the lines he had anticipated. There had been some doubt as to the meaning of "appreciation," but it surely implied judging a thing at its value; it was therefore absurd to suppose that ignorance could appreciate.

Mr. HIBBERT, replying for the motion, again insisted on the importance of Science from the utilitarian point of view.

The CHAIRMAN then summed up, and put the motion to the House. On the call for a division, there voted:—For the motion, 5; against, 24. The motion was therefore declared lost.

A hearty vote of thanks to Mr. Ormond for taking the chair concluded the proceedings.

Papers by Guy's Men.

The Common Cold: its Pathology and Treatment. With especial reference to Vaccine Therapy. By R. W. Allen, M.B., B.S. Lond., Illustrated. *The Lancet*, 28th November and 5th December, 1908.

Post-diphtheritic Heart Failure. By J. Macdonald Gill, M.D. Lond. *The Australasian Medical Gazette*, 20th October 1908.,

A Clinical Demonstration of Selected Skin Cases. By G. Norman Meachen, M.D., B.S. Lond., M.R.C.P. Lond. *Medical Times*, November 28th, 1908.

Three Lectures on the Pathology and Treatment of Diabetes Mellitus, viewed by the Light of Present-day Knowledge. By F. W. Pavy, M.D. Lond., LL.D. Glasg., F.R.S., Lecture II. *The Lancet*, November 28th, 1908.

Prophylaxis in Acidosis following Anæsthesia. By F. Herbert Wallace, M.R.C.S. Eng., L.R.C.P., and E. Gillespie, M.B., F.R.C.S. Eng. *The Lancet*, 5th December, 1908.

Tubercular Peritonitis.

CLINICAL LECTURE BY Dr. W. HALE WHITE.

Gentlemen.—Two cases of tubercular peritonitis in children are at present under my observation, and you see both before you. The first is that of this boy, six years old, who was admitted to the hospital on November 12th. The reason for his admittance was a very considerable swelling of the abdomen. There is a strong history of consumption in the family. An uncle and a cousin have died of it, another cousin has tuberculous hip, the father has it, and one of the patient's brothers also has it The patient had only been ill for a fortnight before he came into the hospital. The illness began with a general feeling of being out of sorts. Five days before admission he was sufficiently unwell to remain in bed. Three days before he came in, the doctor noticed that the abdomen was very prominent. At the time of admission the temperature was 103·2°, the pulse rate 128, the respiration 28. The much-distended abdomen was resonant, as it is even now (December 3rd), but the note is not so good in either flank as it is in the middle. There is a well-marked thrill across the abdomen. When it is palpated, soft doughy masses can be felt here and there. The umbilicus has been getting more and more prominent, red, and inflamed, and you will now notice a considerable red area around it. This change in the umbilicus is a point specially to be noted. The patient has not got on well since he has been in the ward; in fact, he has become rather weaker, and his general condition is worse. On November 18th a Calmette test was done, and was negative.

The other case before you is that of a boy of twelve, who was admitted to the hospital on September 28th. He suffered from pain in the abdomen, and about a week before he came in it was noticed that the abdomen was becoming enlarged. About the same time he began to feel pain after meals. On admission he was found to be very pale, wasted, and subject to sweats. The very distended abdomen was then thirty inches in circumference around the most protuberant part. The distension was most marked in the upper part. There was a thrill and the part was tender. It was perfectly clear that there was a great deal of fluid. His circulatory system was good at that time, and the urine was healthy, but there was very considerable pyrexia, and he has had pyrexia more or less ever since he came in. We were quickly able to determine that he was suffering from chronic peritonitis of some kind or other. This diagnosis was arrived at from the shifting dulness and the thrill, and from being able to exclude heart disease, kidney disease, and cirrhosis of the liver, any of which might give rise to fluid in the abdomen. Local disease of the peritoneum being plainly marked, we had to decide upon its precise nature. It appeared to be most unlikely, considering the age of the patient, that he should be suffering from simple chronic peritonitis. Ultimately we concluded that it was a case of tubercular peritonitis, and directed our treatment to that diagnosis. But when the Calmette reaction was employed the result was negative; indeed, in both these children it was negative, and, that being the case, it appeared as if our diagnosis of tubercular peritonitis was wrong. But the illness came on suddenly, his temperature was very high, and he was obviously very ill. It was thereupon suggested that the micro-organism causing the peritonitis might be the pneumococcus and not the tubercle bacillus. His blood-count was taken, and it was found that there were 8,500 leucocytes in 1 c.mm. of blood, which was strongly adverse to an invasion by the pnemococcus, for that usually causes a leucocytosis. At the same time the tubercular opsonic index was high—viz., 1.93. Examination of the blood, therefore, showed us that the disease was tubercular, and thus our first suspicion of tubercular peritonitis, which the negative Calmette reaction had shaken, was confirmed.

The cases of tubercular peritonitis which do the best are those in which there is a quantity of free fluid in the peritoneal cavity. There was free fluid in this case, and on October 1st it was decided to open the abdomen and let it out. This decision was made for three reasons—(1) because the patient was a good case for operation, there being much free fluid; (2) because he was getting worse and weaker; (3) because the opsonic index of his blood was high, showing that he was suffering very severely from tubercular infection. The abdomen was opened by Mr. Steward, and forty ounces of greenish-yellow fluid withdrawn. After the operation the temperature became lower and the boy seemed to be doing well. But unfortunately, by 10th October the temperature had risen again, and there were signs of re-accumulation of fluid in the abdomen and of pleurisy at the left base. On the 19th of the same month the temperature still remained high, and the boy was very pale and perspired a good deal. Owing to the fact that

he had signs at the left base and was not doing well and remained feeble, we came to the conclusion that the tubercle was becoming generalised in the pleural cavity as well as in the peritoneum. He also had diarrhœa, suggesting that the tubercle had infected the intestines. On October 26th he had improved somewhat, the pulse was better, he took his food better, and the diarrhœa had ceased. While there has been, on the whole, an increase of the pulmonary signs during the last few weeks, the child has improved a little and gained some weight, but, on the other hand, the abdomen is more distended, the operation wound, as you see, is very red, and masses can be felt in the region of the omentum. I have already said that the Calmette reaction was negative, although in this case the one per cent. solution was employed. Tuberculin has been given subcutaneously without much advantage, and the patient is now taking tuberculin by the mouth. In the course of a few days the other boy—the first case—will also be given tuberculin prepared from his own bacilli.

We will now discuss both these cases. The fundamental point in both cases is the presence of fluid in the abdomen. Having excluded heart disease, kidney disease, and cirrhosis of the liver, the next thing to prove was that in both these children the collection of fluid in the abdomen was due to some form of peritonitis. We call it chronic peritonitis because it has been going on for so long a time. This condition may be due to malignant disease, or it may be what is known as simple chronic peritonitis. The latter is a condition in which at present no micro-organisms can be found, although doubtless some day one will be discovered. In these cases the fluid re-collects very rapidly. I had one case, a woman, concerning whom you will remember I lectured last winter, who was tapped seventy times before she died. Such cases, however, do not occur in children, so far as I know, and we were forced to the conclusion that these two were neither malignant nor simple peritonitis. It did, indeed, strike me that in the second the peritonitis might be due to the pneumococcus, chiefly because of the sudden onset, but the low white cell count and the high tubercular index precluded that suggestion. We decided that they were both tubercular in character, and that the children were suffering from tubercular peritonitis. By tuberculous peritonitis I mean peritonitis of which we believe the primary cause to be the tubercle bacillus. By the time these cases come for treatment the infection in the peritoneum is often mixed. I had a case a year ago in which both the pneumococcus and the tubercle bacillus could be cultivated from the discharge at the umbilicus. But even if there is a mixed infection, the leading feature in these cases is tubercle.

Statistics differ considerably as to whether males or females are the more subject to this condition. Probably they are about equal. The percentage of cases of tubercular peritonitis to deaths from all causes also varies greatly according to different observers. By some, the proportion is said to be as high as sixteen in a hundred; by others, as low as about one in a hundred. Another question in dispute is whether tubercular peritonitis is often primary—that is, whether the peritoneum is the first organ affected. Most people think not. The fact is that usually, by the time of the post-mortem examination, nearly every organ in the body is affected with tubercle. Already, in both the cases I have been describing the lungs are affected and several tubercular glands would certainly be found at an autopsy. This important fact we do know, that many cases are undoubtedly due to the spread of the disease from tuberculosis of the female genital organs. There is a general impression, which certainly the above cases tend to support, that tubercular peritonitis is commoner among children than among adults. The figures, however, do not bear out this suggestion. Out of 538 cases gathered from literature :—

30	were under the age of	...	10	
112	were between the ages of	...	10	and 20
137	" "	...	20	" 30
122	" "	...	30	" 40
93	" "	...	40	" 50
31	" "	...	50	" 60
11	" "	...	60	" 70
2	were over the age of	...	70	

Thus, even allowing for the larger number of people living at the younger ages, the cases of tubercular peritonitis are commonest, not in children, but in young adults. These figures, however, represent post-mortem examinations, and as the cases often linger on for a long time, the ages at which the disease first appears will be somewhat before those given in the above table. If one went solely into the post-mortem room and never into the wards, one would get an idea that tubercular peritonitis is far commoner than it is in the wards. It is very usual in the post-mortem room to see tubercle scattered about the peritoneum, even

when such tubercles have during life given rise to no signs of tubercular peritonitis.

Speaking of post-mortem appearances leads me to describe what may be seen at an autopsy and what goes on during the disease. It is the old story, correct interpretation can only come from watching post-mortem examinations. Tubercle bacilli become deposited in the peritoneum and set up chronic inflammation which leads to an effusion of fluid, clear and straw-coloured, sometimes—and this is an important point—containing blood. The next thing to be observed is that these tubercles in the peritoneum aggregate together, forming, with the inflammatory products around them, masses which tend to caseate. Very often these caseous masses become so large that they can be felt through the fluid and give one the impression of dough-like masses in the abdomen. Having got thus far, we can easily picture to ourselves what we find at an autopsy. When the abdomen is opened, the first thing to be observed is the fluid. More than that, there is evidence of chronic inflammation. The caseous and fibroid change has led to the formation of a great many adhesions between the various organs. Indeed, the whole of the intestines with other organs adherent can be taken out in one mass, and it would be a work of hours to dissect out the intestines from that mass. Indeed, the whole of the abdominal contents in such a condition has been aptly compared to an abdomen into which a lot of plaster-of-Paris has run. The organs are so caseous and fixed that they cannot be separated. When we do dissect the organs we shall find quantities of fluid in between the coils of the intestines, showing that in this condition not only is there free fluid, but fluid is also loculated among the various organs. There will also be a great deal of fibrous tissue which will lead to contraction, the contracted omentum becomes puckered, and gives rise to a thick band across the upper part of the abdomen. The wall of the gut is usually weakened by tubercular inflammation and has become rotten. Abscesses are formed in between the coils of intestine. They may have burst externally, and they often burst in several places into the bowel, so that various internal fistulous communications are formed. In one of the cases I described, the umbilicus is seen to be red and inflamed. Underneath that umbilicus possibly some of the mesentery is adherent, and certainly a locular collection of pus will soon burst at the umbilicus, probably also it will burst into the bowel and we shall have a *fæcal* fistula.

As a result of this tubercular change in the peritoneum, one is not surprised to see many tuberculous glands, but these can rarely be felt during life. If in the early stages of the disease there is free fluid—and in the mild cases only free fluid—there is shifting dulness and thrill. If the fluid is loculated there may be a thrill across, but no shifting dulness. Another clinical manifestation is the distension of the abdomen, partly due to the fluid, but still more due to the fact that the peritonitis affecting the wall of the gut causes paralytic distension. The prominence of the umbilicus has been already mentioned. In the early stages the prominence is due to the fluid opening it out; in the later stages it is due to the tubercular masses which are adherent to it, and which are forming an abscess at that point. Later on, the fibrous tissue in the mesentery contracts, and the bowels are drawn back. One cause of intestinal obstruction is tubercular peritonitis. It was Dr. Fagge who, over thirty years ago, said that the frequent cause of intestinal obstruction was what we call compression of the bowel and contraction of the mesentery. On seeing a case in the post-mortem room one would wonder how it was ever possible for the patient to have got his bowels opened at all, or how the intestinal contents were forced along the canal. It is well to remember that, in some cases, there may not be much free fluid, but a great deal of fibrous tissue. A patient may have tubercular peritonitis with a retracted abdomen. We may be caught napping if we imagine that fluid is always present.

The general symptoms need not detain us long. The patient is wasted, partly because he has fever, partly because of the tuberculous process, partly because all this matting together of the stomach and the intestines gives him indigestion. He will have a high temperature, because he is being poisoned by the products of the tubercle bacilli circulating in his system and keeping up the temperature. He will have a rapid pulse, and will sweat a great deal. The thing of particular importance, however, to which I wish to draw your attention is that neither of these children gave response to Calmette reaction; in the case of the elder, even a 1 per 100 solution was negative. A year ago, when we did not know so much about Calmette reactions as we do to-day, a child was admitted to Clinical who appeared to have tubercular peritonitis. Tuberculin was administered in the eye, according to the Calmette method, but there was no reaction. Thereupon it was positively affirmed by some that it could not be a case of tubercular peritonitis,

and in deference to this opinion the diagnosis was expunged, and the lame diagnosis "vomiting and diarrhœa" was substituted. The child died; and at the post-mortem examination the case was shown to be one of the worst examples of tuberculous peritonitis that I have ever seen. Since then I have had three cases of tubercular peritonitis in which the Calmette reaction has been negative, and a number of cases pointing in the same direction have been published. It appears as though, when the tubercular process is very severe, the Calmette reaction is not given. When, for other reasons, we think that a patient is suffering from tubercular peritonitis, the fact that there is no Calmette reaction may be of great prognostic significance. Thus, both of the cases I showed you to-day are desperately ill, but in neither is there Calmette reaction.

Is it easy to diagnose tubercular peritonitis? I do not think it is difficult. In most of the cases the fundamental thing is the distension of the abdomen due principally to fluid. Other causes for this can be readily excluded. Kidney disease, for instance, very rarely gives rise to ascites without other specific signs as well. I cannot recall a case of lardaceous disease happening to complicate the diagnosis of tubercular peritonitis. Cirrhosis of the liver is often associated with ascites, but it is generally easy to make a differential diagnosis. The patient has some swelling of the feet, indicating cirrhosis, or the fluid is free and not loculated as it is here. In cirrhosis there is never the feeling of lumps that the caseous masses will give in tubercular peritonitis. If the alcoholic patient, however, has tuberculosis, it may be very difficult to discover whether the swelling of the abdomen is due to cirrhosis or tubercular peritonitis. People suffering from cirrhosis, however, are often jaundiced, and this almost never occurs in tubercular peritonitis. Moreover, ascites due to cirrhosis is usually a terminal event, preliminary to the death of the patient, while it is often associated with tubercular peritonitis from the beginning. Malignant disease may give rise to some confusion, because there may be the feeling of lumps, as in tubercular peritonitis. But the lumps are harder in malignant disease, and usually other organs —the liver, for example—can be made out during life to be affected with malignant disease. Therefore one is usually led aright in the diagnosis. There only remains the question as to whether the disease is tubercular peritonitis or simple chronic peritonitis. I have never known a case of tubercular peritonitis, however, which had to be tapped so many times as simple chronic peritonitis, and therefore we can say that, as a matter of clinical experience, the diagnosis of tubercular peritonitis is not difficult.

As to treatment, the first essential is plenty of good food, and an appropriate choice of food. We apply the same mode of treatment, so far as food is concerned, as to a patient suffering from phthisis. Patients do better if a considerable portion of the food is fats and carbohydrates. The next essential, as also in phthisis, is fresh air. The boys whose cases I have described are going to be put out on the balcony, although the weather is cold. One boy who was desperately ill six or seven years ago and was given up by the doctors was sent to a sanatorium, and received appropriate nursing and plenty of good food. He remained at the sanatorium for two years, his temperature came down, he got well, and he is now earning his living as a clerk, and the tubercular peritonitis is quite cured. The sanatorium treatment is the ideal treatment for this disease. Then there is the vexed question of operation. Patients who have much free fluid are more likely to do well, whether operation takes place or not. Nevertheless, so many patients have been operated on with success, that there is no reason why, when the fluid is free, it should not be let out, and the patient given the chance which previous experience has shown to follow upon that course. It is surprising, however, to find how small a proportion of cases are suitable for operation. The fact is that many of the cases in which benefit has followed from letting out the fluid have been put on record, so that we have an exaggerated idea of their number in proportion to that of the cases in which an operation is not wise or possible. When there is much loculated fluid and many tubercular masses, no attempt should be made to open the abdomen. If an operation took place in such a case the surgeon would probably grope about in the attempt to try to get into the peritoneal cavity, would be prevented by the numerous adhesions, and sooner or later the intestines would be torn. If there is uncertainty whether free fluid is present, and if there are adhesions, let operation alone. When an abscess forms at the umbilicus, the temptation to open it is extreme. It is essential that it be let alone, for sooner or later it will burst, and it is much better that it should be left to burst without interference. If it is operated upon, fæcal fistulæ are more likely to form than if it is let alone. In cases in which there is a great deal of free fluid and the abdomen is opened, the parts should not be touched beyond the extent necessary for letting

the fluid out, which should be allowed to flow out gently. The tubercular glands must be let alone, and so must tubercular female genitals, and the surgeon be content with letting out the fluid. I said earlier that tubercular peritonitis patients often have a mixed infection of their peritoneum. When the tubercular abscess bursts at the umbilicus, and the micro-organisms can be found, a proper vaccine may do good. In one case tubercle bacilli and pneumococci were found in the pus. We gave the patient tuberculin without much benefit, but the moment that the pneumococcus vaccine was given he began to improve, the sinus closed up, and the response was satisfactory. My impression is, that if the case is very acute, little good will be done with tuberculin. On the other hand, if the case is chronic, and especially if the infection is mixed, to vaccinate the patient against both the infections will be a course probably productive of good.

The prognosis is very difficult. One of the determining factors is the presence of tubercular disease elsewhere. Unfortunately many cases are accompanied by a high temperature, sweating, and also diarrhœa and wasting. No case of tuberculosis will do well so long as there is wasting, diarrhœa, and sickness. If syphilis is present, the patient does not easily recover. There are few associations of disease I like less than the association of syphilis and tubercular diseases. Fæcal fistulæ cases do badly. But one should never give up hope, and I have already mentioned how one apparently desperate case—that of the boy who was sent to the sanatorium—made a perfect recovery.

Guy's Physiological Society.

Dr. Hertz presided at a meeting of this society on Monday, November 30th, when a paper was delivered by Mr. W. S. George, on "Sleep." The author mentioned the various physiological conditions which cause or accompany sleep:—Absence (as far as possible) of external stimuli; partial relaxation of muscles; low blood pressure; low respiratory quotient, &c.

Experiments on animals, and disease in man, have shown how utterly indispensable is sleep to all higher organisms. Many theories have been propounded to explain both the cause and the necessity of sleep. These may be divided into three main classes:—

a. Chemical.—That during waking hours some product of brain activity (*e.g.*, lactic acid) accumulates, so that the brain requires a period of rest in which to get rid of this product. The results of experimental injection of lactic acid, however, do not tend to support this view.

b. The Histological or Dendritic Theory.—This theory supposes that the dendrites are capable of contraction or retraction, and that such retraction breaks down the paths of nerve impulses through synapses, with the result that no nerve impulses can enter or leave the higher parts of the brain. This theory, however, although it can be used to explain most of the phenomena of sleep, has very little evidence to support it.

c. The Cerebral Anæmia or Vaso-motor Theory.—This theory, which is based mainly upon the work of Arthur Durham, of this hospital, supposes that sleep is due to a decrease in the quantity and velocity of blood supplied to the brain; this decrease being due, as stated by Howell, to dilatation of the skin vessels, a condition which is always found in sleep. This change in the distribution of the blood is supposed to be due to a periodicity of the Vaso-motor centre, which, again, may be the result of a chemical stimulus.

After discussing these theories at length, the author wound up with some interesting remarks on dreams, and on the stages passed through in waking from a deep sleep. During the discussion, the chairman pointed out that histological evidence in favour of the "Dendritic theory" has recently been obtained from the brains of hibernating animals.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

B.S., Bournemouth.—Specially stained preparations taken from the centrifugalised deposit of this urine show a considerable number of tubercle bacilli.

C.D.P.S., Huddersfield.—Reaction, acid. Sp. gr. 1019. Blood, *vide infra*. Sugar absent. Albumen a considerable amount. Microscopical examination of the centrifugalized deposit: The deposit contains much mucus and a little pus, many vesical cells and bacteria, and a few triple phosphate crystals; red blood discs are scarce, and no tube casts are observed. Specially stained preparations do not show any tubercle bacilli. The bacilli seem to be almost all of the Bacillus coli type, but there is probably also some urea fermenter, such as the micrococcus ureæ. We have not separated the organisms by the usual cultural methods, because this is hardly worth the cost except in case of a catheter specimen in a sterile bottle.

H.L., Manchester.—This warty papilloma consists of a fibrous core covered by proliferating epidermis. There is some evidence of commencing infiltration at the base and some tissue reaction here: hence we conclude that it is becoming malignant. It is, however, in a very early stage.

PATHOLOGIST.

Reviews, etc.

The price of books submitted for review should in every case be stated.

Husband's Practice of Medicine, designed for the use of Students and Practitioners. Sixth edition. Re-written and enlarged by Robert F. C. Leith, M.A., M.Sc., M.B., C.M., F.R.C.P. Edin., Professor of Pathology and Bacteriology, Birmingham, and Robert G. Fleming, M.A., M.D., F.R.C.P. Edin., Assistant Physician, Royal Infirmary, Edinburgh, Lecturer on Principles and Practice of Medicine, School of Medicine of the Royal Colleges, Edinburgh. (E. & S. Livingstone, Edinburgh.) Price 12s. net.

We have read this book through from cover to cover, and we do not recommend it. We can quite understand that there may be certain provincial examinations where the standard of knowledge required is no higher than has been aimed at in this instance, but for the requirements of the London student we are quite certain that the book will be found wanting. The book seems to aim at giving a knowledge of medicine which is far too popular. Many of the articles are strongly suggestive of those paragraphs which appear from time to time in the enterprising daily press of the age, written by "a medical man of wide experience" under the heading of "The Family Physician." The book, it will be noted, is designed for the use of students and practitioners, and on behalf of the latter it would naturally be supposed that all references to treatment should be clear and definite, or, at any rate, suggestive. Many of these, however, remind us very much of a little book commonly read by the newly-appointed extern, giving him first lines as to the details of his craft, and occasionally warning him that if certain symptoms appear he is "to send for assistance." Final directions and dogmatic teaching are often avoided. Now we would submit that no man, even of considerable experience, should be allowed to teach such a subject as medicine, still less to put his pen to paper, unless he is prepared to impart to his hearers or readers, as the case may be, the beliefs which he holds as a result of that experience. There is too much at the present day of copying from one text-book to another. To give a list of drugs or to enumerate methods of procedure is not sufficient. The student, bewildered with the making of many books, and handicapped with a short hospital life, naturally looks for something definite from his own particular authority, and, if he fails to find it, his case is a sorry one. We hold that it is the business, nay more, the bounden duty, of the medical author, if he has any right to be considered as such, to set down in black and white his own opinion, even supposing that it differs from every other authority, to say boldly, "This drug, in my opinion, is most serviceable; that drug is useless," or again, "I know of no remedy which can alleviate this complaint." In these respects the book is often deficient. Then, again, the authors fall into a common error of neglecting the relative importance of different diseases. Every medical student will come in contact with measles; many are the troublesome complications and sequelæ of the complaint. On the other hand, very few indeed will ever see a case of hydrophobia. To write a book for *students* giving a full account of the latter complaint and dismissing the former in three small pages, of which one page is devoted to ætiology and the incidence of the disease among the South Sea Islanders, is, to say the least of it, unwise.

Running through the book, we notice that in an otherwise good account of diabetes mellitus, the writer fails to explain the diminution of the sugar and the increase of urea in the urine, which is noticed with the onset of diabetic coma. This point is, for the student, the chief difficulty. No attention is drawn to a sign upon which any sister in the medical wards would lay stress, namely, that with the onset of diabetic coma the patient, whose appetite has been voracious, suddenly refuses food. Under the heading of the diagnosis of malignant endocarditis, no mention is made of the frequency with which the disease may be mistaken for pernicious anæmia or general tuberculosis. Discussing the treatment of lobar pneumonia, we note with interest that strophanthus is cited as the best cardiac tonic to administer, and we would endorse the plea for the early administration of oxygen at definite intervals. With regard to the treatment of acute intestinal obstruction, it is recommended that there should be given "sufficient opium, either hypodermically or by the bowel, to alleviate pain until surgical assistance can be obtained." Again, under the heading of appendicitis, "the medical treatment consists in . . . . the administration by the mouth, should there be no vomiting, of some sedative such as opium." This is certainly not Guy's treatment, and we recommend any clinical who should advance such statements to certain surgeons of our acquaintance, that in doing so he stand only on the far side of the bed to them, and no nearer. The classical work of Dudgeon and Sargent upon the bacteriology of peritonitis is all against the use of the drug in any cases where there may be a possibility of inflammation, but as we read further on (referring to the organisms found in acute peritonitis), "that it does not seem to be necessary to calculate which of them occurs oftenest," it is quite obvious that the authors neglect the all-important work which has been done by the above-mentioned observers at St. Thomas's Hospital. In writing of acute leptomeningitis the authors describe the tuberculous as a primary form of meningitis, but go on to say that such a classification is based purely upon symptomatology. Surely the only possible basis for a logical classification of disease is one that is based upon morbid anatomy. We believe we are right in saying that strictly primary tuberculous meningitis is unknown in the Guy's post-mortem room with its seven hundred autopsies a year. Writing of chronic acquired hydrocephalus, the astounding statement is made that "pressure on the veins of Galen by a tumour is the commonest cause," while "closure of the Foramen of Majendie brought

about by meningitis is a much less frequent cause." Again, in an article upon chronic anterior poliomyelitis (p. 917), we are told that "in the early stages it may be mistaken for paralysis of the ulnar nerve, but the interossei do *not* suffer in the latter." We cannot explain these inaccuracies.

As was pointed out above, the great fault of the book is that there is a want of dogmatic teaching upon just those subjects with which a student is certain to require assistance for clinical work. Possibly this is owing to dual authorship. The method of making tables comparing various diseases is very suggestive of the work of the "crammer," as distinct from the clinician, and tends to breed a race of medical students who endeavour to learn medicine, not at the bedside, but in the class-room; not with the patient, but with the "Aid to Medicine."

When to Operate in Inflammation of the Appendix. By C. Mansell Moullin. (John Bale, Sons & Danielsson.) 3rd Edition. Price 2s. 6d. Pp. 48.

We can well recommend this little book to our readers. For here, in the space of an hour's reading, whether one agrees with it or not, is food for many hours' thought. Mr. Moullin first discusses the very slight attacks that go by the name of appendicular colic, and then takes the acute fulminating cases where peritonitis is general from the very first. He then considers the wide range of cases that lies between these two extremes, and it is in these cases that his advice will be found so valuable.

First, then, are the cases which are seen from the beginning by the practitioner, and in this series he gives us two conditions where he advises immediate operation. There are those where the symptoms are severe from the very beginning of the acute attack, and here he warns us that the beginning of the acute symptoms is not the beginning of the disease, but, on the other hand, the actual inflammation of the appendix has begun some three or four days before. Again, there are the cases which start with mild symptoms, and steadily grow worse in the first forty-eight hours, or have a sudden exacerbation at any period of the disease.

Secondly, he discusses the cases which do not come under observation until the third or fourth day, and in these cases he maintains that the continuation of any one single symptom is an indication for operation; it must not be thought, when three or four of the main symptoms are better, that the patient is better, if in any one point improvement has not occurred.

The last lecture is devoted to the value of each symptom, taken separately, as an indication for operation.

Perhaps the most striking thing to note in these lectures is the close resemblance to the teaching one hears in our own wards, in spite of the fact that Mr. Moullin is discussing what is often thought to be one of the most debateable subjects in medicine and surgery. Another point is the multiplicity of indications for operation that are given, so much so that one is inclined to think that we are told to operate in every case of appendicitis that is seen. True, certain cases are hinted at which are not put down as indications for operation, but these are but passing references, and the cases are not clearly outlined. So many authorities will tell us numerous cases in which we should operate that we eagerly look for some lecture or paper on the indications not to operate in cases of appendicitis, either from the pen of Mr. Mansell Moullin, or from some other authority; what cases exactly are suitable for treatment by rest and careful diet; in what cases, again, is the treatment advised by Dr. Oschuer, of Chicago, advisable, where the patient is propped up in bed and given only saline by the rectum or subcutaneous tissue, and absolutely nothing by the mouth. He tells us that by this treatment certain cases may be saved which would not be by operation. We feel sure that some teaching from this point of view would be eagerly welcomed by many.

Therapeutics of the Circulation. By Sir Lauder Brunton, Bart., M.D., D.Sc., F.R.C.P., F.R.S. (John Murray.) Price 7s. 6d. net.

This book, which is dedicated to Professor Kronecker, consists of eight lectures delivered in the Physiological Laboratory of the University of London. The volume, possibly on account of the fact that it is an adaptation of verbatim reports of lectures, without the lecture experiments, does not read well. Abrupt transitions from one part of the subject to another produce a displeasing effect on the reader. The first four lectures deal with the physiology and pathology of the circulation. In the first chapter, a considerable amount of attention is paid to the opposite views of nervous *versus* muscular conduction in the heart. The author inclines to the view that the nerves are important factors in the transmission of the normal beat. A short appendix at the end of the volume contains a few notes on the work of Professor Kronecker and some of his pupils on the same subject. They are very interesting, but not, in our opinion, quite convincing. Self-massage of the heart and vessels also receives a prominent place. Chapters V. and VI. deal with methods of treatment, and the action of drugs on the heart—digitalis, caffein, strychnine, and aconite receiving most attention. The last two chapters give views on various heart affections. Heart-block might have been included in these chapters. The venous pulse is also omitted. On page 55, line two from the bottom, a sentence occurs in which one is led to infer that peptone mixed with blood will delay clotting. This is erroneous. On page 222, line 17, the word "renewed" should be "removed," The book is profusely illustrated; some of the illustrations have apparently suffered in reproduction, and some are superfluous. We recommend the book to our readers, but they must not expect a complete treatise on such a large subject in so small a compass.

The Abbott Versimetric Charts. Published by A. Couchman, the Medical Agency, Watergate House, Adelphi, W.C.; and 34, Paternoster Row, E.C. Price 1/- each, mounted; post free 1/1.

Until the metric system is definitely adopted in this country, and so long as our antiquated grains and

minims are mixed up with grams and cubic centimetres in text-books and reports, both scientific and commercial, it is imperatively necessary that anyone who constantly requires to convert measures from the one system into the other should have at hand some quick and easy means of doing this without wasting time on calculations. There are, of course, elaborate tables for this conversion obtainable, but these are necessarily limited in range, and are apt to be mislaid just when they are wanted.

To meet this need, these Versimetric Charts, suggested by Mr. F. E. Fremantle, M.B., and Mr. H. Finnemore, B.Sc., have been devised by Mr. Thomas W. Abbott, and by their means conversion from one scale to the other is easily, quickly and accurately effected. Each chart consists of a ruled sub-divided square, whose ordinates represent the British units, and abscissæ the metric units. A diagonal line connects the corresponding points on the two scales. The method of using the chart is therefore obvious.

Eight of these charts are published for the conversion of weights, lengths, volumes and temperatures, and two special charts suitable for anthropometric work in connection with the medical inspection of school children.

The series, as a whole, should prove invaluable to chemists, medical officers, surveyors, and all who have to deal with figures in the two systems.

It remains only to say that the charts are printed on Japanese paper, 15 × 18 inches, and are provided with a wooden roller and metal loop ready for hanging.

Mental Deficiency. By Dr. A. F. Tredgold. (Ballière, Tindall & Cox.) Price 10s. 6d. net.

Oceanus, the watery element, was worshipped in the River Nile by ancient devotees who held this flowing flood a great god in their Egyptian theology. The river was called the life-giving Father of existence. It need not be suggested that the dean and chapter of St. Paul's Cathedral should straightway sally forth from their ecclesiastical seclusion and bow the head and bend the knee before the Thames at Blackfriars Bridge or by the Temple steps. Yet there is still something to be said for the methods of past as opposed to those of latter-day theology. The ancients had this virtue, that they were in their religion in all things sincere and practical, and went to the very causes and foundations of things, whether good or evil. This is an admirable and a sensible attribute, and, unless it be too late, worth imitating even now.

It may be at once admitted that a work entitled "Mental Deficiency or Amentia" will appeal to medical men. It is a compendious mass of most useful material for the inspiration of the student interested in the various phases of mental unsoundness. The author of the volume gained the Research Scholarship in Insanity and Neuropathology established by the London County Council. Without attempting to criticise these pages, which will inevitably appeal to the professional mind, we commend them to the social reformer and also to the theologian.

If modern preachers were to follow the example of their Egyptian predecessors, it must be admitted that they would appeal more practically to medical men. There is no reason why the teachings of the pulpit should not be those impelled by a scientific spirit of radical investigation. It must be well to go down deep, and to ascertain the very foundations of life and the things that are fair and those that are most fatal. There is a disease called religious mania. It is responsible for many sad hearts and sorrowing homes. It might, perhaps, be right for preachers to try to learn and to distinguish between those theological tendencies and ideas that drive men mad and those profounder religious convictions that make their lives true and keep their minds safe and their brains sound.

In the sphere of social reform, an ancient Egyptian would have believed implicitly in the purifying principle, as flowing from the watery element and through the worship of the Nile. The strain of insanity in the body politic is one of the most terrible and devastating, despite the increasing mastery attained by medical men over the fierce and subtle forces of mental degeneration. Social reformers should give greater and more sincere attention to this failure in the national and civic organism, and bestow greater assistance than that which is at present afforded upon the faithful labours and the enlightened direction of the medical profession.

Intemperance is often the result, but frequently the cause of insanity, and the real remedy would appear to the impartial to lie not so much in passing purely external laws as in rectifying the internal minds of men. Physiology is interwoven with psychology, religious revelation with bodily soundness, and physical vigour with moral validity.

McLachlan's Applied Anatomy. Revised by A. A. Scot Skirving, C.M.G., M.B., C.M., F.R.C.S. Edin. (E. & S. Livingstone). 4th Ed. 2 vols. Price 18s. net.

Mr. Scot Skerving has had a difficult task to perform in editing Mr. McLachlan's well-known work on Applied Anatomy. When the pen of the original author of a work is laid aside, fortunate indeed are the publishers who can obtain an efficient substitute. We congratulate the editor on the result of his work. Much is expected of the Edinburgh School, and of any work which emanates from it. Our hopes and expectations are fully realized after a careful perusal of this work.

So many works on Applied Anatomy, nowadays, merely consist of straight lines, squares and figures, which any student could put together for himself perfectly well, had he the necessary time and money. There is little originality about most of such works—much less originality than wrong information.

This work, however, is a notable exception to such a rule. The book is of a convenient size, the binding, printing, paper, and illustrations are admirable, and we can honestly recommend it to a man up for his final examinations, even though they be the higher ones.

The special articles on the eye, ear and nose are excellent, that on the eye especially so.

When we turn to particular points, the ligature of arteries and the anatomising channels in the limbs are very well described. We are particularly pleased with the description of the ligature of the lingual artery in two places, and that such terms as, "ligature of an artery in continuity," are explained. Great stress is laid upon the appearance of veins in the living body, a point of great importance to the student. The description of the joints, and the operations performed upon them, is also full of sound information.

We consider that some of the diagrams would be improved if the side of the body from which they are taken were indicated, *e.g.*, that on page 121, in the first volume. We think the domed molars associated with congenital syphilis might have been mentioned.

Mr. Symonds' incision for thyroidectomy is not mentioned. This is a serious omission. Surely the author of the anterior incision for excision of the hip is Parker, not Barker.

Mr. Davies-Colley's method of treating fractured shaft of the humerus is omitted. As this method is perfectly simple in application and efficient in its result, it should have been mentioned. Barker's method of wiring the patella is said to be still used by many surgeons, but surely not, as a general rule, in civilised countries. No mention is made of Mr. Bucknall's operation for hypospadias, which has been attended with such good results.

The branch which the ovarian artery is said to send to the appendix, has finally received its *quietus* from the late Professor Birmingham's work. We are glad to gather this piece of information about a statement, which we never believed.

To one statement we must seriously object. The arterial blood is not, in many cases, dark with ether or gas anæsthetisation, as indicated on page 2, vol. I. If the contrary is the case in Scotland, it may explain why chloroform is such a favourite anæsthetic in that country.

We are glad to see the suggestion made that the use of the point named after, possibly by, McBurney, should be discontinued. There is little method about the point; and there is little point in the method of McBurney for compressing the common iliac in cases of amputation at the hip-joint, as mentioned in vol. I., page 220.

We again congratulate the author, editor, and publisher on the results of their work. We wish the book was more often seen by London students.

Periodicals received. — The Hospital; The Clinical Journal; The Prescriber; St. Bartholomew's Hospital Journal; London Hospital Gazette; Indian Medical Gazette; Calcutta Medical Journal; University College Union Magazine.

Notice.

UNIVERSITY OF CAMBRIDGE.

Examinations for Medical and Surgical Degrees. Michaelmas Term, 1908.

PLAN OF EXAMINATIONS

(subject to alteration in details, of which due notice will be given).

First Examination.

Part I. Chemistry and Physics.—Monday, December 14th. 10 a.m. to 12 m., Mechanics, Hydrostatics and Heat. 2 to 5 p.m., Chemistry. Tuesday, December 15th., 10 a.m. to 12, Electricity and Optics. 2 to 5 p.m., Practical Chemistry and Oral Examination in Chemistry—in the University Laboratory. 2 to 4 p.m., Practical Physics and Oral—*in the Cavendish Laboratory*, Division I. Wednesday, December 16th, 10 a.m. to 1 p.m., Practical Chemistry and Oral Examination in Chemistry. 10 a.m. to 12, Practical Physics and Oral—in the Cavendish Laboratory, Division II. 2 to 4 p.m., Practical Physics and Oral—in the Cavendish Laboratory, Division III. Thursday, December 17th, 10 a.m., Oral Examination in Chemistry and Practical Physics continued, if required. Friday, December 18th, 10 a.m., Oral Examination in Chemistry and Physics continued, if required.

Part II. Elementary Biology.—Wednesday, December 16th. 2 to 5 p.m., Elementary Biology. Friday, December 18th, 9 a.m. to 12, Oral and Practical Examination in Elementary Biology—in the Biological Laboratory.

Second Examination.

Human Anatomy and Physiology.—Monday, December 14th, 9 a.m. to 12, Human Anatomy I. 1 to 4 p.m., Human Anatomy II. Tuesday, December 15th, 9 a.m., to 12, Physiology I. 1 to 4 p.m., Physiology II. Saturday, December 19th, 9 a.m., Section A, Practical and Oral Examination in Physiology—in the Physiological Laboratory, 9 a.m., Section B., Practical and Oral Examination in Anatomy—in the Anatomical School. Monday, December 21st, 9 a.m., Section A., Practical and Oral Examination in Anatomy—in the Anatomical School. 9 a.m., Section B., Practical and Oral Examination in Physiology—in the Physiological Laboratory.

Third Examination.

Part I. Pharmacology and General Pathology.—Monday, December 14th, 9 a.m. to 12, Pharmacology (paper). 2 to 5 p.m., General Pathology (paper). Thursday, December 17th, 9 a.m. to 12, Oral and Practical Examination in General Pathology—in the Medical Schools. 2 p.m., Pharmaceutical Chemistry (Oral and Practical)—in the Chemical Laboratory. Friday and Saturday, December 18th and 19th, 9 a.m. to 12, Oral and Practical Examinations in Pharmacology. 9 a.m., Oral and Practical Examinations in Pharmacology and in General Pathology—in the Medical Schools.

Cards with details of Practical and Oral Examinations in Pharmacology and General Pathology to be distributed at Written Examination.

Opening Night of the Charterhouse Mission Boxing Club.

THIS took place on Tuesday, November 24th, at eight o'clock, at the Club's Hall in Crosby Row. Dr. E. P. Minett, who for the last two or three years has done so much to stimulate interest in boxing at Guy's, arranged the programme, and the Revs. F. G. Croom and J. G. Vassall, the clergy attached to the Mission, occupied the chair and vice-chair. The large hall was crowded with an enthusiastic audience, and the fare provided proved much to their taste.

Owing to the length of the programme, it will be impossible to describe in detail the various events, but it may be mentioned that three out of the five Olympic boxing champions, Messrs. R. K. Gunn, F. Grace (the well-known Eton Mission man), and A. L. Oldman, gave their services in the boxing exhibitions, and performers of scarcely less reputation appeared in Messrs. Holmes, Condon, Mann, Webb, Perry, Warner, P. A. Jones and Chris Clarke, all of whom, with the exception of Condon —one of the most improved and promising of the boxers of to-day—have held championships. Dr. Minett had hoped to box himself, but an attack of influenza, which compelled him to keep his bed for several days till late in the afternoon of the performance, unfortunately prevented him.

The chief interest to Guy's men would lie in the appearance of their representatives. A gymnastic display on parallel bars was given by Sergeant Gilbert, the instructor, and Messrs. Oram, Lewis, Penny, Mitchell, Reynolds, Barraclough and G. O. Eccles. Although the height of the hall made some of the more complicated manœuvres difficult, their work was well and cleanly done, and was much appreciated. A club-swinging exhibition was also given by Messrs. Oram, Eccles, Mather, Mitchell and Reynolds, in which luminous clubs were swung in a darkened hall, to the accompaniment of Mr. K. H. Hole's piano. A special word of praise should be given to Mr. R. G. Oram for his keenness and enthusiasm in bringing down such an excellent team. In an exhibition of épee, G. H. Haycraft of Guy's secured three hits to two of S. H. Scott, the London man, and W. Kemp, the Guy's man, boxed three rounds with Pye. His opponent was older and heavier, but Kemp showed cleverness in evading punishment, and fought doggedly to the end.

Among the events which were especially popular, must be mentioned the two exhibitions of wrestling given by the brothers Bacon, of whom E. V. is the Olympic champion. Their first bout was in the Cumberland and Westmoreland style, and their quickness and strength was well displayed. A. J. Bacon on this occasion secured four falls to three. Subsequently they gave a display of catch-as-catch-can, in which no fall was secured after five minutes. We do not remember ever having seen a man of better symmetrical muscular development than E. V. Bacon.

The Handcuff King, who, if we remember rightly, appeared two years ago at Guy's, also gave a most interesting exhibition, concluding by getting out of a complicated mass of leg-irons, and handcuffs, connected by chains to a band round his neck, in under two minutes. Possibly the most popular boxing bout, if one can be singled out, was that between F. Grace and Chris Clarke, the ex-9 stone champion. Grace has filled out in the last two years without losing any of his cleverness and quickness, and the bout was very fast and most interesting.

Mention should also be made of the kindness of the City Police, more than a dozen of these members appeared in the various bouts, and of Dr. B. H. Steward, late of Guy's, who acted as timekeeper. Dr. Allport was also noticeable among the onlookers.

We wish space permitted us to give a more detailed account, but it must suffice to say that the vote of thanks to the performers and all connected with the entertainment, which was moved by Mr. Croom, met with the heartiest possible response.

Sport.

Rugby Football.

GUY'S v. NEWTON ABBOT.

After seven home matches in succession the hospital team journeyed to Newton Abbot, and played the local club, on Saturday, November 28th. Archer, playing for his county, and Mullins and Williams being engaged at the hospital, were unable to lend their assistance. Owing to suspensions, and a variety of causes, Newton Abbot were not able to put their strongest fifteen in the field, but this alleged weakness was counterbalanced by the inability of the above hospital men to turn out.

Guy's had the advantage of a stiff wind during the first half, and Newton Abbot kicked off, a good crowd lining the ropes, and encouraging the local champions with an immense amount of "lung power," which swelled into a roar as Prudence and Badcock made a very dangerous incursion into Guy's territory, but Lee, Jones, and Lacey were very alert, and early gave promise that their defence would require a deal of piercing to fall; but fall it did, temporarily, as a scrum ensued, and Squires secured the ball and bounded over with a try, which Bunclark failed to goal. Lacey was next prominent in stopping an ominous forward rush. Guy's forwards retaliated, and the play swung to the other end, where Medlock, with a blind side move, gained a try, which Stokes missed goaling. Soon afterwards, a very fine run by Stokes ended in a brilliant try, but though Stokes' effort at goal was good it was not successful. At half-time the hospital therefore led by 6 points to 3.

Good forward work by the hospital pack was the feature of the opening of the second half, but Newton were the next to score; Lacey followed up a kick, but Polyblank got away and, clearing his opponents, landed

a try, which Bunclark converted. Newton looked like increasing their lead, but Barrett "muffed" when well placed. Then numerous "scrums" in the visitors "25" took place, from one of which Squires put on an unconverted score. With a 5-point lead Newton pressed, and Lacey put in some good work, aided by his centres and Stringer, till danger being warded off Guy's played a freer game and, the forwards again on the move, Newton were forced back. Jones and Stringer put in a good run, and then a really good bout of handling got the ball to Stokes, who raced over, and, kicking a very excellent goal from wide out, the game thus ended in a draw of 1 goal and 2 tries (11 points) each. Team:—

GUY'S.—G. E. W. Lacey (back); L. B. Stringer, H. Lee, J. P. Jones, L. Stokes (three-quarters); J. G. Saner, A. H. Medlock (halves); G. R. Hind, A. H. Crook, H. Hoby, A. Moberley, H. Stranach, C. G. Sprague, T. D. Stout, A. Seabrooke (forwards).

REMARKS.—Lacey was very good indeed, whilst Jones and Lee were also admirable. Jones, during the latter portion of the game, played at outside half, obviously his proper position. Of the wing men, Stringer's opportunities were limited, while Stokes played much better, his two tries being distinctly good. All the forwards played well, and Moberley signalised his reappearance by showing to great advantage.

GUY'S v. NORTHAMPTON.

With Archer, Jones, and Hind playing at Richmond, and Lee and Crook engaged elsewhere, the Hospital were not able to send their strongest XV. down to Northampton last Saturday, (December 5th). The forwards who deputised did remarkably well, but the novel three-quarter line did quite the reverse. Only Stringer played at all well, and he was in better form than on any previous day this season. There were about 4,000 spectators present when the Hospital kicked off, and after a few minute's play Guy's got into the home "25," but here Coles intercepted and brought relief; within, however, about ten minutes of the start Coles got over with a try quite in the corner, which he converted himself, with a fine kick. Soon Mobbs made a good run, but he was well collared, and then passing by Harrison, Mobbs and Beazeley cleared the way for Cook to put on a try, which Coles failed to majorise. After the drop out, Guy's forwards put in some good work, and then Coles tried a drop which failed, and Stringer, gathering, romped away, but no score resulted. A few minutes before half-time Mobbs got over the line, but lost the ball, then Birch dribbled up from midfield and tackling Duke before he could get in his kick, the ball came across to Cook who scored on the right. Coles kicked a goal, and thus Northampton led at the interval by 13 points to nil.

Roe, whose old injury had been troubling him, retired finally soon after play restarted. Roe's tackling and general play had suffered, doubtless through his foot giving way again, and with Lacey going much too "high," and Stokes failing to go for his man either "high or low," the home right wing had been able to develop their passing movements unchecked. But this second portion opened in more promising style, as Stokes soon put on 4 points, dropping a goal at long range. Good passing by the Northampton quartette gave Guy's an anxious time, and ere long Cook threw wide to Coles, who landed an unconverted try. The game was, however, very interesting, the hospital trying their utmost to reduce the odds, and Stringer, after two splendid attempts, managed to gain a try, which Stokes just failed to goal.

Northampton speedily replied with another score, as Ridgway kicked past Duke, and, though the latter got to the ball, Cook managed to kick it over and touch down, but no goal resulted. Guy's were not yet done with, for the forwards, still going in great style, worked down, and from a scrum Saner sent Medlock over with a second and last try for the hospital. Stokes' kick failed, and the final score was: Northampton, 2 goals, 3 tries (19 points); Guys, 1 goal (dropped), 2 tries (10 points). Team:—

GUY'S.—H. L. Duke (back); L. B. Stringer, G. E. W. Lacey, A. S. Roe, L. Stokes (three-quarters); J. G. Saner, A. H. Medlock (halves); H. R. Mullins, W. E. Williams, H. Hoby, C. S. L. Roberts, H. Stranach, C. G. Sprague, T. D. Stout, A. Seabrooke (forwards).

REMARKS.—The forwards deserve great praise for putting up a great fight and working so pluckily throughout, notwithstanding the poor work at three-quarters. Saner and Medlock were quite sound, and Duke did all and a bit more than one has a right to expect. Stringer played a good game; his tackling was certain and his running reached a high standard. But the attacking powers of the other "threes" were not very evident, and their defence was poor indeed. Lacey shonld endeavour to break himself of the habit of going for the head or shoulders; it is not effective, and it most certainly is not good play. Stokes must learn to tackle; he lets his man past time after time, thereby throwing so much work on his centre and full-back that it is almost a wonder no more than 19 points were scored against us.

Association Football.

GUY'S v. EASTBOURNE.

This match was played on Saturday, November 28th, at the Saffrons. Guy's proved a big attraction, there being fully 800 spectators present when the Hospital kicked off. At the outset our forwards got away, King putting in some good work on the right wing. Some midfield play followed, and then each side attacked in turn. Up to this stage, neither goalkeeper had been seriously troubled, but Rudd then gave Rook a hot handful, which the latter cleverly disposed of. King, splendidly fed by his partner, was proving the most dangerous of our forwards, and it was from one of his centres that Jones, left unmarked in a favourable position, opened the scoring with a shot that gave their goalkeeper no chance (1-0). Straight from the kick-off, Coleby ran through our defence, and scored with a delightful cross shot (1—1).

Just after this he was again responsible for two further efforts which deserved to score. Guy's then assumed aggressive tactics, and they were again given the lead by King, whose header Ticehurst just failed to negotiate after dealing with a shot from Jones. Within a few minutes the hospital, who were quicker on the ball than their opponents, had gained a further advantage, for a mistake by Lee gave King a chance to score which he was quick to take.

Just before the interval several unsuccessful onslaughts were made on the visitors' goal. Gardner who was splendidly marked by Pedrick, had been able to do very little during the first half, but directly after the restart he got away and put in a shot which, however, just hit the outside of the net. Shortly afterwards the referee, without consulting the linesman, awarded the homesters a very doubtful point, a cross shot from a corner which hit the left post, but did not appear to cross the line, being allowed (2—3). Guy's retaliated almost immediately, Jones defeating Ticehurst at close quarters. Midfield exchanges then ensued, the hospital having slightly the best of the argument. The second corner of the match fell to the seasiders, and was nicely placed by Gardner. Although hampered by several opponents, Toswill got in his shot, but it struck the upright—a creditable effort. During the closing stages of the game darkness began to set in, and just before time MacGregor reduced our lead with a high dropping shot, which Rook just failed to prevent entering the net (3—4).

REMARKS.—Rook in goal played a very sound game, making some fine saves. He had absolutely no chance with the shots that scored, except perhaps the last goal which was obtained in semi-darkness. Our backs, Hole and Johnson, played a very useful game, and tackled strongly, but were rather slow in getting the ball, too often taking the man and leaving the ball to look after itself. The halves were all good, Humm getting through a lot of work, while Pedrick so well looked after Gardner as to make him absolutely ineffective. Edey proved that he can play equally well in any position. Of the forwards, King was at his best, which is saying a good deal. His centreing was quite the feature of the match; while the two goals he scored were the result of excellent football. Jones, who is in quite a scoring mood at present, played a very good game, his shots giving the goalkeeper no chance. McManus, at centre, did not get through much work, but was hampered by receiving a heavy charge on his arm during the earlier part of the game. Mitchell at outside left is improving considerably, and if he can get over his anxiety to score, should make a very capable winger.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated.*

Appointments.

Civil.

ALLEN, R. W., M.B., B.S. Lond., has been appointed Clinical Pathologist to the Mount Vernon Hospital.

CLARKE, W. TRAVERS, M.R.C.S., L.R.C.P. Lond., has been appointed School Medical Officer for Morley, Yorks.

GREENE, C. W., M.B., B.C. Camb., M.R.C.S., L.R.C.P. Lond., has been appointed Senior House-Surgeon to the Miller Hospital, Greenwich.

MORICE, CHARLES G. F., M.D., M.R.C.S., L.R.C.P. Lond., to be Port Health Officer for the Port of Greymouth, N.Z.

OLIVER, W. GRANT, L.D.S., has been appointed Dental Surgeon at the Royal Naval Barracks, Devonport.

Naval and Military.

Staff-Surgeons PERCIVAL M. MAY, R.N., and F. DAVIDSON LUMLEY, R.N., are promoted to the rank of Fleet-Surgeon in His Majesty's Fleet.

Surgeon H. G. T. MAJOR, R.N., has been appointed to the *Spanker*, Surgeon F. M. V. SMITH, R.N., to the *Vivid*, and Surgeon A. T. RIVERS, R.N., to the *Lord Nelson*.

1st Eastern General Hospital:—R. A. MILLIGAN, M.D., to be Major, R.A.M.C.

4th Southern General Hospital:—H. W. WEBBER, M.D., M.S., to be Major, R.A.M.C.

The King's Own (Royal Lancaster Regiment): BERTRAM W. HOGARTH to be Captain.

Royal Field Artillery:—Surgeon-Lieutenant C. GORDON ROBERTS. M.B., from the Essex Imperial Yeomanry, to be Surgeon-Lieutenant, with precedence as in the Imperial Yeomanry.

Births.

BLACK.—On December 1st, at the Willows, Hailsham, Sussex, the wife of George Black, M.B., B.S.Lond., of a son.

FAWCETT.—On November 20th last, at 66, Wimpole Street, W., the wife of John Fawcett, M.D., of a daughter.

WHATLEY.—On November 8th, at Knowle, Warwickshire, the wife of J. L. Whatley, M.R.C.S., L.R.C.P. Lond., of a daughter.

Death.

ELLISTON.—On November 27th, at Scothorne House, Felixstowe, William Alfred Elliston, M.D., J.P., in his 69th year.

ED.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

December.

Sat. 26. Boxing Day.

Thur. 31. Messrs. Symonds and Steward's Take-in (Messrs. Sanford and Ewing).

January.

Sat. 2. 1st XV. v. Catford (Home).
2nd XV. v. Catford (Away).
1st XI. v. Eversleigh (Home).

Mon. 4. Second half of Winter Session begins.
Clinical Lecture by Dr. Horrocks (Gynæcology), 1.15 p.m.
Physiological Society Meeting, 4 p.m.

Thur. 7. Messrs. Lane and Fagge's Take-in (Messrs. Leeming and Johnson).

Passim.

FIRST and foremost, it is the Passimist's duty—and pleasure comes at the same time as duty in this particular instance—to wish everyone, who is or has been connected with Guy's Hospital, the conventional, but none the less genuine, wish of a Merry Christmas and a Happy New Year. Whether they read these words or not, it is more than probable that those who are with us no longer, but are stationed at their work in various parts of the great world, will be reminded by the return of Christmas time, of former Christmases in the wards here, and all the work and play, and happiness and folly, which we associate with the season. They cannot fail to be pleasant reminiscences.

To those still in our midst, it is probable that definite information will be more welcome than sentimental abstractions. We therefore have much pleasure in presenting the following programme of Christmas festivities :—

Thursday, December 24. 6.30 to 9 p.m.—The Southwark Cathedral Choir, under the direction of Dr. Madeley Richardson, will make a tour of the wards and sing carols.

Friday, December 25. Christmas Day.—THE OUT-PATIENTS' TEA from 2 p.m. onwards.
The Niggers go round, starting at 12.30 p.m.

Saturday, December 26. Boxing Day.—Concerts in JOB (3.30), PATIENCE and SAMARITAN (4.30) Wards.
Christmas-tree in CHARITY Ward, 3.
First Night of the RESIDENTS' THEATRICALS, Physiological Theatre, 8.15 (Part I., "Charles I. and Charles II."; Part II., Concert; Part III., topical farce, entitled, "The Dean's Dilemma," or "The Sister, the Socialist and the Statue").

Monday, December 28.—Concerts in MARY (3.30) and QUEEN (4) Wards,
Christmas-tree in MARTHA Ward, 3.
RESIDENTS' THEATRICALS, 8.15.

Tuesday, December 29.—Concerts in ADDISON (4), LAZARUS (5), and EYE Wards (4).
LUKE and CORNELIUS Wards; Concert in Physiological Theatre, 2.30.
RESIDENTS' THEATRICALS, 8.15.

Wednesday, December 30. Nurses' Entertainment.

Thursday, December 31.—Concerts in STEPHEN (4) and ASTLEY COOPER (7.30) Wards.
Bonfire, 11.30 p.m.

IT may be mentioned that the Residents have this year adopted the principle of division of labour in the arrangement of the various Christmas entertainments. Thus Mr. H. J. Henderson is responsible for the Niggers, and Mr. P. S. Price

for their band. We understand that Mr. A. L. Gardner has written some delightful harmonies for several of the songs; he has also composed the music for the Residents' play. In connection with the Nigger band, we also hear that it has been found impossible to deter the President of the Residents from beating the big drum, and that the Vice-President will therefore carry the archaic pole! Mr. Syms is supervising the general arrangements for the ward concerts, and Mr. B. H. Palmer is stage-manager, Mr. A. S. M. Palmer, business manager, and Mr. C. B. Ticehurst, property manager to the Residents' Theatricals. Division of labour undoubtedly makes for efficiency, but, after all, there must be one at the head of affairs. Needless to say, Mr. Dryland fills this important position.

In addition to the ordinary ward concerts, a party of vocalists and instrumentalists, under the direction of Mr. L. C. D. Irvine, will visit most of the wards during Christmas week, and perform trios, quartets, etc., from the Gilbert and Sullivan operas.

Though our hospital motto is "Dare quam Accipere," we do not claim any monopoly in the sentiment it expresses, and are always ready to receive the gifts of our many generous sympathisers. At Christmas time, when these gifts take the form chiefly of toys and Christmas fare, the widespread sympathy and charity towards our hospital becomes especially manifest. We are glad to hear that this year there have been received even more of these practical expressions of kindliness than in former years.

The marriage rate of the Staff has, during the present month, reached a record height, for three weddings among them during one month must surely be an unprecedented occurrence. Dr. Eason, Mr. Turner, and Mr. Mollison have all been married within eight days of one another. The three happy couples have our heartiest congratulations, and sincerest wishes for continued health and prosperity. We trust they will not expect three separate congratulatory paragraphs, for the Passimist, acting as Hymeneal Registrar, would have been quite unable to find different greetings suitable to the occasion in each case.

All Guy's men will be glad to hear that on the 11th of this month the Academy of Medicine of Paris awarded the Godard Prize of 1,000 francs to the work of Dr. F. W. Pavy on "Carbohydrate Metabolism and Diabetes," translated by Dr. Aigre.

The subject of our Christmas picture for this year is Dr. Thomas Addison. Sir Samuel Wilks, who is one of the few living Guy's men who knew Addison personally and worked under him, has, in answer to our request, very kindly sent some reminiscences of the great physician, which, together with some account of Addison's life and work, will be found on another page. Our portrait is reproduced from a photograph which, according to Sir Samuel Wilks, is a very good likeness.

While greater alterations are in progress in the Out-patient department, there is a minor improvement in the hospital — minor, but none the less long-desired—which is worthy of mention. We refer to the renovation of Patience and Samaritan which has taken place during the autumn. It is true these wards are still attics, but very smart and convenient attics now in comparison with those that have been familiar to generations of assistant surgeons' dressers. The latter, and the nursing staff, will have cause to bless the improvements in these wards, even if, to the superficial observer, the changes may not be very numerous or radical.

Two novel schemes, whose success will be watched with interest, have been instituted at two of the London hospitals in connection with their Out-patient departments. At the Middlesex hospital, observation wards have been established for the reception of "patients, whose injuries or ailments, though not serious enough to justify immediate admission to the wards of the hospital, are nevertheless of a character sufficiently severe to render discharge after ordinary casualty treatment unwise." This plan certainly seems to have possibilities, for

the disadvantages of admitting patients to the ordinary wards for two or three days only, and, on the other hand, the advantages of not sending doubtful cases out of the hospital at once, are obvious. At the Middlesex Hospital, at any rate, these observation wards seem to have justified their existence, for during the six months since they were started, more than 150 patients have been admitted to them. Further particulars, such as the average length of stay of the cases, should prove interesting.

The other scheme to which we referred has been initiated at the Westminster Hospital, where the Governors have been enabled to make a new departure in out-patient treatment, through the munificence of Lady Campbell Clarke. At the Westminster, as at ours, and all large hospitals, it is only too commonly the case that patients coming up for treatment need food quite as much or more than they need medicine. We have no means of remedying this difficulty, and yet much of our treatment must be in vain so long as patients are insufficiently and improperly fed; malt extract and cod liver oil are, no doubt, very excellent in their way, but they can hardly take the place entirely of bread, and meat, and milk. By the new fund at the Westminster Hospital, some remedy for this state of affairs will be available. Its object is to provide food for such necessitous cases, under the direction of the visiting staff, as may require it. The meals are to be given in the hospital itself, but certain provision is made which will enable such things as milk to be taken away for the benefit of those, such as children, who may require it frequently. Obviously this is only a palliative measure, but as such it may prove useful; at any rate, it may relieve some physicians and surgeons in charge of out-patients from the ironical necessity of prescribing drugs for a starving patient.

Periodicals received. — The Hospital; The Clinical Journal; Middlesex Hospital Journal; St. Mary's Hospital Gazette; Charing Cross Hospital Gazette; South African Medical Record; Manchester Medical Students' Gazette; Manchester University Magazine, Polyclinic; Ceylon Medical Students' Gazette, St. Thomas' Hospital Gazette.

Correspondence.

To the Editor of Guy's Hospital Gazette.

A Couple of Reforms.

Dear Sir,—May I suggest a reform that is much needed, and one that might very appropriately be carried out in these days of general benevolence and good-will?

Every day one may see numerous patients walk to the gate facing the College, only to be sent back by the Porter there with the remark "Other way out, please!" No doubt it is highly desirable that the gate in question should be kept private, but we cannot expect our Borough patrons to regard the question in this light, and the way in which the rule is enforced must seem unreasonable and high-handed to them.

I would suggest that a notice-board at the corner with a suitable inscription would obviate a good deal of unnecessary work and not a little bad language.

Also, why not paint up Mr. Rowlands' Orthopædic Out-patient day on the Board in St. Thomas's Street, and avoid the annoyance of those persons coming up on ordinary Surgical Out-patient days?—I remain, yours faithfully,

X. Y. Z.

The Therapeutics of Egg-Shells.

Dear Sir,—I was rather interested to see in the last issue of the Gazette the letter from T. R. Atkinson, with the recipe of a "lung tonic." I have, curiously enough, come across a patient who has been taking this weird mixture of eggs, egg-shells, lemon-juice and rum, with apparently great benefit.

The case was a woman who had been under my care originally three years ago, with extensive phthisis of both lungs. For over two years, under fresh air treatment and Cyllin, though a bath-chair invalid, she just held her own. On seeing her a fortnight ago, I found her, to my astonishment, much better. The pulse-rate was slower, she could walk about, and the physical signs in the lungs showed a wonderful improvement. On inquiry, I found that she had been advised, when in Cornwall, to take the egg-shell mixture. This she had done for six months, leaving off all other medicine, and she had been making definite and continued improvement ever since.

In view of the recent notes in the *British Medical Journal* as to the value of calcium salts in phthisis, the improvement may well be more than a coincidence.—I am, etc.,

GERALD S. HOVENDEN, M.D.

Kitson Lodge, Barnes, S.W.,
14th December, 1908.

Thomas Addison.

WHEN, a few years ago, a series of portraits of celebrities connected with Guy's was instituted by the GAZETTE for its Christmas pictures, a start was naturally made with the portrait of our founder, Thomas Guy. Then followed in order: our most famous physician, Dr. Bright, and our most famous surgeon, Sir Astley Cooper; last year, our second greatest benefactor, William Hunt, was the subject of the picture; and this year we are reproducing a photograph of Dr. Thomas Addison, who must be accounted second only to, if not the equal of, Dr. Bright in the roll of our physicians, and whose name is universally associated with a disease more definite than either Bright's or Hodgkin's.

HIS LIFE.

The story of Addison's life is uneventful, and is soon told, for he was absorbed in his work, held no Court appointments, and mixed little with other men.

He was born in April, 1793, at Long Benton, near Newcastle, and was thus by birth a Northumbrian, but his father lived, and his family had been long settled as yeomen, at the Banks, near Lanercost, in Cumberland.

Next to nothing is known of his early life, except that he received his chief general education at Newcastle, where he must have acquired the excellent knowledge of Latin which he afterwards displayed. From school he proceeded to Edinburgh to commence his medical studies, and there he graduated M.D. in 1815, his thesis being "De Siphilide." He obtained further experience in this subject when, shortly after, he went to London in order to practise his profession, and was appointed house-surgeon to the Lock Hospital, and he always spoke on the subject with authority. He also gained a wide knowledge of skin diseases from his experience under the celebrated dermatologist, Dr. Bateman, at the Public Dispensary, and his knowledge of these diseases was afterwards applied in the perfection of the wax-models in our museum, many of which were made under his direction by Towne. At this time he was living in Skinner Street, Snow Hill; he afterwards moved to Hatton Garden, where he earned fifty pounds by his practice in the first year, and a hundred in the second and third. He became a Licentiate of the College of Physicians in December, 1819.

Addison's connection with Guy's Hospital began in 1820. Entering probably as an ordinary student, he soon attracted the attention of Benjamin Harrison, the famous treasurer, who, in 1824, appointed him assistant physician, in spite of the fact that he was, so to speak, an outsider. There were other candidates for the post, and in selecting Addison, the treasurer provided one more example of those autocratic actions which were so amply justified by results. Three years later Addison found scope for his powers as a teacher by receiving the appointment of lecturer on Materia Medica, and his popularity in this direction was at once established. His first published work, "On the Operation of Poisonous Agents on the Living Body," was produced in 1829.

In 1837 he was appointed full physician, and also joint-lecturer on Medicine with Dr. Bright; the two physicians intended to collaborate on a text-book of Medicine, but, like the work of Dr. Hilton Fagge in later years, this remained unfinished, and only one volume—the greater part of it written by Addison—was published. A year later he became a Fellow of the College of Physicians. During the following years he wrote various papers on pneumonia, phthisis, and other subjects, and in each case he made original observations of interest and importance. The disease especially associated with his name also began to attract his attention at this time, but he made no public announcement of the discovery until 1849, when he read a paper on the subject before the South London Medical Society,* and even then the publication of the work was deferred for five years.

Apart from his practice and teaching at the hospital, Addison's life was uneventful. He lived in Spring Gardens, near Bransby Cooper's house, and had a good, but probably not very extensive, practice. He did not marry until he was over fifty. Threatening onset of mental disease compelled his retirement from hospital duties in the spring of 1860, and at this time he wrote, "A considerable break-down in my health has scared me from the anxieties, responsibilities, and excitement of the profession; whether temporarily or permanently cannot yet be determined . . .;" but it proved to be permanent, for his mental depression increased, and his death at Brighton, under distressing circumstances, was soon afterwards—on June 29th—announced.

Addison was buried under a great yew tree in the churchyard adjoining Lanercost Priory at his home in Cumberland. All his life he had been much attached to his ancestral home; his annual holiday was always spent there; and shortly before his death he paid it a last visit.

* *Medical Gazette*, March 15th, 1849.

An account of his sensations on this occasion has been left by his friend Dr. Lonsdale: "I cannot help recalling my last day with Addison at Banks House, on the eve of his departure for London in September, 1859. It was Sunday, the atmosphere clear and balmy, and the sun descending, when we walked upon the lawn in front of the family residence. Looking from this high position—one of the most picturesque and extensive views in Cumberland—Addison regarded it with intense delight, and, as if prophetically impressed with its being the *omega* of his home joys, exclaimed, 'What can be more heavenly than this!'"

The photographs which will be found reproduced as an inset to this number of the GAZETTE, represent the gateway to Lanercost Priory, and Addison's tomb, respectively. The latter has recently been inspected at the request of the GAZETTE Committee by Dr. Muriel, of Whitehaven, who kindly reports that it is in a good state of preservation.

His Work.

Addison's work was to such a large extent his life, and its results in published form are so few in number, that it is worth while to give them in full. They are as follows:—

1. "An Essay upon the Operation of Poisonous Agents" (jointly with John Morgan, Surgeon to Guy's Hospital). 8vo., London, 1829.
2. "Observations on the Disorders of Females connected with Uterine Irritation." 8vo., London, 1830.
3. "Elements of Practice of Medicine" (jointly with Richard Bright, M.D., but, as stated above, chiefly written by Addison). Vol. i. only published. 8vo., London, 1839.
4. "On the Constitutional and Local Effects of Disease of the Supra-renal Capsules." 4to., London, 1855.

Addison also published various papers in the Guy's Hospital Reports, of which the following, together with (2) and (4) above, were collected as "*The Works of Dr. Addison,*" published by the New Sydenham Society in 1868, under the editorship of Dr. Wilks and Dr. Daldy:—(i.) "Observations on the Anatomy of the Lungs;" (ii.) "Observations on the Diagnosis of Pneumonia;" (iii.) "Observations on Pneumonia and its Consequences;" (iv.) "On the Pathology of Phthisis;" (v.) "On the Difficulties and Fallacies attending Physical Diagnosis in Diseases of the Chest;" (vi.) "Observations on Fatty Degeneration of the Liver;" (vii.) "Case of Ovarian Dropsy removed by the Accidental Rupture of the Cyst;" (viii.) "On a certain Affection of the Skin, Vitiligoidea—(α) Plana, (β) Tuberosa;" (ix.) "On the Keloid of Alibert, and on True Keloid;" (x.) "On the Disorders of the Brain connected with Diseased Kidneys;" (xi.) "On the Influence of Electricity as a Remedy in certain Convulsive and Spasmodic Diseases."

Interest naturally centres chiefly round the work on disease of the suprarenals, in which another new disease—pernicious anæmia—called by Addison "idiopathic anæmia," was also described; the clear differentiation between the two diseases was afterwards made by Sir Samuel Wilks. The history of this best-known work of Addison's, which by the way was "less valued by his own pupils and immediate successors than his earlier works," is exceedingly interesting, and some particulars of it are given by Dr. Gibson in an address which he delivered before our Physical Society,* and by Dr. Hale White in a recent clinical lecture.† The name "Addison's Disease" seems to have been suggested by the great French physician, Trousseau.

Addison the Physician.

It is recorded of Addison that once, "after seeing a patient within the radius of eight or ten miles, he remembered on his near approach to London, thinking over the case on his way, that he had omitted some seemingly important inquiry, and he posted back some miles for the purpose of satisfying his mind on the doubt which had occurred to it." The story throws light on his character as a physician. With him diagnosis was an all-important object to pursue; if "he could lay his finger on the disease, his victory was attained, and his painstaking satisfactorily rewarded." To a case for diagnosis he brought marvellously acute observation and infinite care and patience in examination, often passing from one side of the bed to the other in order to use the ear in which he had the best hearing, and often wearying out his class by his untiring zeal in investigation. On one occasion, pondering during the night over a case in the wards, he remembered that he had not examined the patient for hernia; nothing would satisfy him but that he must dress, take a cab to the hospital, and startle the sister of the ward by his appearance in the middle of the night, in order to decide the point. The same minuteness and exactitude marks the reports of cases which he published, and it was Addison who, in 1828, instituted the regular method of systematic case-taking at Guy's which has continued to the present day.

* *Guy's Hospital Gazette*, October 19th, 1907.

† *Ibid.*, October 17th, 1908.

This enthusiasm for diagnosis (and for pathology, which, after all, is only diagnosis carried to the extreme point) left him little enthusiasm for treatment. On one occasion, when called to see an obscure case of abdominal disease, he devoted much time and patience to elucidating it, and at length arrived at a diagnosis of cancer of the peritoneum. He discussed it with the patient's medical attendant, saw the friends, and was about to leave, when he was called back and reminded that he had not written a prescription. When he asked what the medical man was giving, he was told "magnesia mixture," to which he replied, "A very good medicine; go on with it."

A doctor caring so little for treatment was not likely to find much favour with the general public, to whom treatment is of paramount interest, and diagnosis of next to none; and as a matter of fact, Addison never became a fashionable or even popular physician, but as a consultant he gained an unrivalled reputation with his fellow practitioners, and the latter was probably infinitely more to his taste than the former.

ADDISON THE TEACHER.

If there is some doubt as to Addison's success as a practising physician, there is no doubt that he was a born teacher; "his lectures were of a very superior order, extempore, couched in good language, which amounted sometimes to real eloquence. The clinical lectures were most excellent, as he never failed to thoroughly unfold the case which he was discussing, and so, arguing both from positive and negative reasons, he placed the diagnosis on a sure foundation." His clearness of thinking, tendency to dogmatism, and perseverance in diagnosis probably all contributed to his success in imparting knowledge to others. That this success was appreciated by his students is shown in the following letter, which Addison wrote upon his retirement:—"I can truly affirm that I ever found my best support and encouragement in the generous gratitude and affectionate attachment, as well as my proudest reflections, in the honourable and most exemplary conduct of the pupils of Guy's Hospital."

ADDISON THE MAN.

In addition to a commanding personality, Addison had a distinguished personal appearance. He "was of good height and well made, stood erect, with coat buttoned up very high. . . . . He wore a black stock with scarcely visible shirt collar, and this further elevated his head. He had a well-proportioned, good head, with dark hair and side whiskers, large bushy eyebrows and smallish black eyes, nose thick, as were also the lips which enclosed his firmly-knit mouth. His features were not refined, but belonged to a powerful mind, and showed no trace of any kind of sentiment.*

A portrait of Addison as a young man, painted by Charles Des'Auges, hangs in the office of the Secretary to the Treasurer, but is probably not a good likeness. There is also a bust of him in the Royal College of Physicians, and another bust, the work of Joseph Towne, in our own museum, was modelled in 1852. The portrait reproduced by the GAZETTE is from a photograph which hangs in the committee room in the medical school.

As a man, Addison suffered from the grievous drawback of a nervous and despondent disposition. He confessed that he never rose to address even the Physical Society at Guy's without feeling nervous, and to cover this he had to cultivate a certain bluster and haughtiness of manner which was inevitably misinterpreted by some people. Beneath an apparently unprepossessing manner he had, however, much kindliness and generosity of heart, as the following extract illustrates:—

"The year that this distinguished physician was President of the Royal Medical and Chirurgical Society, he invited the reporters of the medical press to meet some of the *élite* of the profession—one of his objects being to show that we were not the ruffians that some professed to think us. The evening was one of the most delightful I ever spent. Addison I had never met in private before; I had only known him as the great physician of Guy's Hospital, and the somewhat apparently haughty and pompous president of two medical societies. I was astonished at his *bonhomie*, his hospitality, and his powers of conversation. All honour to his memory, say I, for this mark of his independence and liberality. . . . Foote, at the dinner in question, was taciturn. We walked home together, and he joined me in eulogising Addison for inviting us at a period when the medical press was under a cloud." †

Always of a melancholic temperament, Addison in his later years became subject to awful fits of despondency, and the most trivial matters began to cause him anxiety. A trial in which he was engaged, and soon afterwards the death of a friend, added to his troubles; and physical and mental disease combined at last to bring him to

* Wilks and Bettany: *History of Guy's Hospital.*

† *Autobiographical Recollections of the Medical Profession.* J. F. Clarke, M.R.C.S. 1874.

the saddest of deaths. How often it is given to the Genius to play a tragic part in the great Drama of life!

Authorities.— The materials for a life of Addison are but scanty. No extended biography of him has ever been published; a short memoir is prefixed to the New Sydenham Society's edition of his *Works*, edited by Dr. Wilks and Dr. Daldy (1868); a somewhat longer account appears in Wilks and Bettany's *Biographical History of Guy's Hospital* (1892). The *Dictionary of National Biography* contains a short life from the pen of Dr. J. F. Payne; it is interesting to note that it occupies only about one-third of the space devoted to Bright. No obituary notice of Addison appeared in the *Lancet;* a fairly extended notice, however, appeared in the *Medical Times and Gazette* for July 7th, 1860. Munk's *Roll of the Royal College of Physicians* (1878), Greenhow's *Lectures on Addison's Disease* (1875), and Lonsdale's *Worthies of Cumberland* (1873), also supply information on special points.

Some Reminiscences of Addison.

By Sir Samuel Wilks, Bart., F.R.S.

When I entered Guy's in the early forties of the last century, Addison was the most notable man there. His personality was at once impressive, as he was of fair height, upright, with a step carrying with it much *hauteur*, or, at least, great authority. His manner and voice were quite in accord, so that it was at once apparent that he was a leader of men. In the wards, when speaking, or more especially when lecturing, his commanding presence, good language, and a little oratory, obliged the students to listen with attention, and with a quiet behaviour very different from that witnessed in some other classes, where the lecturer had no hold of his men. It was a real treat to hear Addison's talk, often adorned with a Latin quotation, as his scholarship was good, and with an occasional outbreak of oratory; as, for example, when he was speaking of the value of electricity, he alluded to Franklin's experiment with the kite, and, raising his arm, in sonorous voice exclaimed, "When Franklin dragged the lightning from the skies!" and then proceeded with his discourse. I might here remark that Addison wrote a paper on the value of electricity in the Guy's Hospital Reports. He was somewhat egotistic in his style, so that all he said was taken as pure gospel, and as his hearers were scattered all over the world, Addison's name and methods of treatment were known and talked of in every country wherever English was spoken; no higher authority could exist.

He began his course with common continued fever. This he divided into several kinds, beginning with typhus. This he spoke of as being complicated with disease of the bowel, or as simple fever without it. When Jenner, by a most masterly piece of work, demonstrated the absolute or specific difference between them, Addison was loath to admit it, and even his younger colleague, Gull, took a considerable time before he gave to it his full adhesion.

He was one of the first physicians of the day to adopt Laennec's method of physical examination of the chest, and probably for this reason he obtained considerable renown for his knowledge of phthisis. He wrote papers in the Reports on pneumonia and on the value of the physical signs on examination of the chest. An elder colleague of Addison spoke of the stethoscope as the new plaything, although he himself made much use of the naked ear. Addison used to relate with much gusto how, in two cases where it was asserted that the lung was diseased, he insisted that the signs were due to pleuritic effusion, and how he thrust in a trocar, and presented the fluid to the eyes of the two respective doubters. Nowaday the class would only smile at the relation. This dogmatic method of Addison was clearly contagious, for I heard once, at one of the chief Medical Societies, a remark, when a young aspirant to fame displayed some conceit in describing his case, that Guy's men thought themselves the *crème de la crème*. I am under the impression that this opinion was the general one at the time, and, if so, it has not been altogether harmful, for it may be as beneficial for an institution to have a little conceit as for an individual to think well of himself.

Addison was also a great authority on skin disease, having had Dr. Bateman as a colleague at the public dispensary. This was long before dermatology was known as a specialist's subject. His remarkable acuteness and penetration prevented his overlooking the discoloration of the skin, increasing usually in intensity until the death of the patient, and which he found to be due to disease of the suprarenal bodies; and yet "morbus Addisoni" was not generally accepted for many years afterwards.

In spite of Addison's power over others, he was a man of nervous temperament, often having fits of despondency, or even melancholia, so that, while still a man of vigour, owing to a number of depressing circumstances he resigned all his appointments at the hospital. This

seemed so tremendous a loss that a deputation, headed, I believe, by the late Dr. Galton, waited on him, asking him to rescind his resolution. His answer was, "My work is over; I have left it for others." He soon afterwards departed from London, and it was not long before we heard of his end—

"*Multis ille bonis flebilis occidit, nulli flebilior quam mihi.*"

Guy's Physiological Society.

A MEETING of this Society was held on Monday, December 14th, when a paper was read by Mr. G. E. Genge-Andrews on "The Physiology of Athletic Training." Mr. Mollison occupied the chair.

The author first commented on the history and objects of athletics. He then considered the effects of muscular work on respiration, and the mechanism by which accommodation is brought about.

Experiments by Leonard Hill, Haldane and Priestly show that carbon dioxide is the chief factor in the production of dyspnœa, although the respiratory centre is undoubtedly affected by lactic acid and other chemical products of muscular activity.

The circulatory system is affected by several factors:—

a. The changes in respiration.

b. Muscular contraction, which assists the flow in the veins.

c. By chemical substances produced, which act on the cardiac centres and probably also on the cardiac muscle.

The result is a great increase in the force and rate of the heart beat.

The dilatation of the skin vessels is more than counterbalanced by the constriction of the splanchnics; hence there is a great rise in blood pressure.

The muscular action on the veins ensures better filling of the right heart, and so the amount of blood supplied to the lungs in a given time is increased, and the oxygenation of the blood goes on more rapidly than before, as also does the excretion of CO_2.

The question of fatigue was discussed, and in this connection Hill's experiments on the power of oxygen in removing fatigue were mentioned.

Much work has been done on the question of diet. Chittenden maintained that the average man takes twice as much protein as is necessary for him. This seems improbable, but the experience of trainers and athletes is that excess of protein should be avoided during training, or "staleness" will result. This is somewhat vague, as the optimum quantity differs for every person.

The author then concluded with some general remarks on the value of athletic exercise to each sex, and to people in various conditions of life.

Appointments.

Medical School Appointments.

Clinical Assistants.—Messrs. H. Chapple, A. H. Crook, H. B. Kent, H. C. Lucey, H. Lee, W. E. Wallis.

Dressers in the Throat Department.—Messrs. C. M. Plumptre, A. A. Greenwood, G. F. Haycraft, R. P. M. Roberts, V. T. P. Webster, P. C. Field.

Medical Ward Clerks.—Messrs. H. F. Stephens, W. T. Chaning-Pearce, G. Maxted, H. F. Montgomery, G. B. Cockrem (Dr. Hale White); M. M. Munden, M. C. Thavara, T. Lewis Jones (Dr. Pitt); G. Dunderdale, F. A. Dick, G. E. W. Lacey, A. D. Vazquez, J. Pryce Davies (Sir Cooper Perry); E. A. Penny, W. E. Fox, A. L. Saul, H. F. Renton (Dr. Shaw); G. R. Hind, H. W. Barber, A. M. Bodkin, N. Mutch, J. M. Jarvie, A. H. Todd, H. T. Depree, L. C. D. Irvine, A. C. Jepson, C. M. Ryley, W. P. Vicary, J. A. Delmege, G. T. Mullally, R. Heaton, T. S. Sharpley.

Assistant Surgeons' Dressers.—Messrs. E. P. Poulton, J. A. Edmond, G. L. Preston, H. H. Davies, H. L. James (Mr. Steward); C. D. Killpack, B. Blackwood, M. C. Wall, A. H. Gool, L. C. W. Cane (Mr. Fagge); A. S. Roe, H. G. B. Blackman, R. Stout, B. T. Verver, G. Y. Thomson (Mr. Rowlands); E. Billing, A. L. Gardner, G. A. Blake, J. H. Campain, H. V. Leigh (Mr. Turner).

Assistant Physicians' Clerks.—Messrs. W. H. Talfourd Jones, T. T. O'Callaghan, C. E. Reckitt.

Post-mortem Clerks.—Messrs. Q. H. Richardson, F. D. Saner, E. L. Elliott, W. H. Talfourd Jones, C. E. Reckitt, T. T. O'Callaghan (Jan.—Mar.); A. L. Fitzmaurice, H. L. Attwater, N. L. M. Reader, R. C. H. Francis, W. S. Kidd (Feb. 16th—May 15th).

Clerks in the Skin Department.—Messrs. A. D. Vazquez, A. C. Jepson.

Aural Surgeon's Dressers.—Messrs. A. A. Greenwood, P. C. Field.

Obstetric Dressers.—Messrs. F. Kahlenberg, H. Steinbach, L. Bromley (Dr. Horrocks); W. L. Hibbert, W. H. Catto, M. M. Adams (Mr. Targett) (Jan.—Feb.).

Surgical Ward Clerks.—Messrs. E. W. Blake, A. Samuel, F. N. Doubleday, E. G. Schlesinger, N. S. Carruthers, H. Daw, O. E. Williams, F. G. Lloyd, G. Marshall, A. Seabrooke.

Assistant Surgeons' Clerk.—Mr. F. B. Bull (Messrs. Steward and Fagge).

Civil.

HOPSON, MONTAGU F., has been re-appointed Clinical Teacher of Dental Surgery at the Royal Army Medical College.

LEWIS, A. C., M.R.C.S., L.R.C.P. Lond., is appointed Certifying Surgeon for the Rochford District, County Essex.

Naval.

Surgeon G. L. Buckeridge, R.N., has been appointed to the *Kinsha*.

The Indications for and some Practical Points in the Performance of the Radical Mastoid Operation.

CLINICAL LECTURE BY Mr. C. H. FAGGE, F.R.C.S.

Gentlemen,—To-day we shall discuss not any individual patient, but an operation which may be termed an ordinary subject for a systematic lecture on Otology. I want to deal with the complete mastoid operation, by which is meant the free laying open of the mastoid antrum and any mastoid cells which may be connected with the antrum, the removal of the posterior bony meatal wall, in so far as it interferes with the drainage of the antrum and cells, the removal of the outer wall of the attic, and then a plastic operation on the soft parts forming the posterior meatal wall, so as to allow the cavity which results from the removal of the bone I have mentioned to drain through the external meatus, after which the post-auricular wound is sutured. This is known as the complete or radical mastoid (Schwartze–Stäcke or Zaufal-Kuster) operation.

1. The first indication for this operation, and by far the commonest, is chronic middle ear suppuration. I suppose of the cases admitted into my beds for a radical mastoid, nine out of every ten come in for chronic suppuration of the middle ear. I have no time now to detail the points on which you would rely in eliminating suppurative discharge arising from the external ear; when both external and middle ears are involved, the latter is always the primary condition, and you will know that where there is chronic middle ear suppuration, there is necessarily a perforation of the drum. So if, on examination, you find a perforation of the drum with chronic ear discharge, you have a condition which may demand the complete operation. But not all such cases demand the complete operation; many get well under antiseptic treatment. One may say, as a general rule, that if middle ear suppuration lasts twelve months, and during three months has had continuous antiseptic treatment, and is not cured, then this operation is necessary. The most important proviso, apart from the three months' treatment and twelve months' duration, is that in children the treatment must include the removal of adenoids, if such are present. I remember one case which emphasises the importance of this; that of a child treated for chronic suppuration in the Ear Department for three years; the adenoids were then removed, and the same treatment was continued, when the chronic middle ear suppuration was well in three months. Therefore it is generally true that if a child with chronic middle ear suppuration has adenoids, the prognosis is good. Conversely, if he has no adenoids, the prognosis is bad; by which I mean that where suppuration and adenoids co-exist, you are fairly safe in saying that if the adenoids are removed, probably the middle ear suppuration will get well under antiseptic treatment. If there are no adenoids, although you may continue the antiseptic treatment somewhat longer, the likelihood is that the radical operation will have to be done. Of 1,000 children who were examined a few years ago by Mr. Arthur Cheatle, of King's College Hospital (see Otol. Soc. Trans., vol. iii., p. 74), and who then or previously had suffered from middle ear suppuration in one or both ears, 72 per cent. had adenoids. There are few children with chronic middle ear suppuration on both sides who have not got adenoids, and I am sure, whatever views one may hold as to other indications for removal of adenoids, that whenever there is middle ear suppuration operation is imperative.

Another condition which may require operative treatment before antiseptic treatment can be given a fair trial is the presence of exuberant polypi in the meatus, where they interfere with the free escape of discharge. The polypi must be removed, otherwise you cannot expect the three months' treatment to cure the otorrhœa, but if they recur, then operation is strongly called for, as the polypi themselves suggest the presence of bone disease. If you were dealing with a sinus in the hip, for instance, and granulations sprang up at the healing edges of the wound, you would take measures to remove them. Remember that polypi in the ear are only masses of granulation tissue, and on account of the shape of the external auditory meatus, these granulations are stalked and pedunculated, hence their name.

If, then, a patient, who has no polypi or adenoids, has chronic otorrhœa of twelve months' duration, which you have treated antiseptically for three months, say with hydrogen peroxide drops, syringing with 1 in 60 carbolic, or formalin 1 in 500, or 1 per cent. lysol, then the complete mastoid operation is indicated.

What does persistent otorrhœa mean? It practically always means that the disease which primarily began in the mucous lining of the middle ear has spread to the underlying bone. The mucous lining of the middle ear and antrum is also the periosteum; and it is not difficult to conceive that disease which began in the

mucous surface very soon affects the periosteum, and so the underlying bone. Assuming that the intractability of the disease is due to involvement of the underlying bone, why deal with it so radically? The answer is, that here the operation is prophylactic; that it is probably true that intracranial complications never result when the mucous lining of the middle ear and of its adnexa is alone diseased. It is because invasion of the underlying bone is indicative of the risk of complications that you need to be active in treatment.

Special points.—(*a*) The commonest position in which the carious process begins is the descending process of the incus, which articulates below with the stapes, and lies behind the upper and posterior portion of the membrane; while the other process of the incus projects backwards into the aditus which leads into the antrum. The descending process is often destroyed. What evidence do you find of this? If, in examining a case of chronic middle ear suppuration, you find a perforation immediately beneath the posterior malleal fold, you may be suspicious of disease of the descending process of the incus, and if within the perforation you see a small isolated white body which you recognise as the head of the stapes, you will know that the descending process of the incus has been destroyed.

(*b*) The anterior and posterior malleal folds lie above the membrana tensa, and below the membrana flaccida (the membrane of Shrapnell): the latter forms part of the outer boundary of the attic, that half of the tympanic cavity which lies above the level of the membrane proper, and which contains the head of the malleus and body of the incus. If you find a perforation in Shrapnell's membrane, the prognosis is bad, because it means disease of the attic wall or of its contained ossicles.

(*c*) Another grave indication, to which I have already referred, is the presence of polypi. So far as I know, polypi never grow from the meatus itself, always from the edge of the perforation, or from the lining of the tympanic cavity: such polypi at first demand removal, after which you may cure the middle ear suppuration. The polypi do not produce the suppuration; they are the results of it; and it is always important to insist that no polypi should be removed until the ear is clean, because it is agreed by all who have to deal with cases like this that the removal of a polypus is often the primary factor in setting up acute intracranial complications. No doubt many people walk about with quiescent inflammatory foci in their brains, then suddenly the infection is lit up by some outside cause; one of the commonest of these causes is removal of a polypus. Its external surface is covered with squamous epithelium, and absorption through this is impossible, but if you remove a polypus from an ear which is very dirty, pus flows over the raw base of the polypus, the patient re-infects his abscess, and urgent symptoms ensue. The last case of cerebellar abscess which I operated upon was one which immediately followed the removal of a polypus, and many years ago, I remember, under the late Dr. Washbourn in Clinical, a case of chronic temporo-sphenoidal abscess, in which acute symptoms occurred ten days after the removal of a polypus in another hospital.

(*d*) A fourth local condition which, in the presence of chronic otorrhœa, suggests the advisability of a complete mastoid operation, is the presence of a fistulous track leading through the bone into the antrum or mastoid cells. This track may come to the surface behind the ear, and it may be in the site of a previous operation, or—and this is much more common—there may be a scar behind the ear which looks healthy and sound, yet when cut through is found to cover over a fistulous track or cavity in the bone containing septic debris. Similarly, fistulous tracks leading from a diseased mastoid process may open on to the posterior wall of the external auditory meatus—a condition fairly commonly due to cholesteatoma.

You will no doubt often be asked what is the risk of intracranial complications, when you have advised a patient with chronic otorrhœa to have an operation to free him from this danger. There is wide variation in the estimation of the percentage mortality derived from voluminous statistics collected by different observers; Bezold estimated it at 1·2, Barker at 2·5 per cent., so that you will be sufficiently accurate if you reply that chronic middle ear suppuration is directly fatal in 2 per cent. of patients affected by it.

2. The second condition imperatively demanding the radical mastoid operation is the onset of acute inflammatory symptoms in chronic otorrhœa. Whenever there are symptoms suggestive of the retention of pus in the antrum, such as headaches, nausea or vomiting, occasional pyrexia, recurrent attacks of giddiness, unrelieved by medicinal treatment, in a patient suffering from chronic otorrhœa, the complete mastoid operation should be done. You may ask whether these symptoms would not demand operation in everybody. Yes, but they would not demand

the complete mastoid operation; the operation would then be antrectomy—or, as it really should be called, antrotomy—otherwise known as Schwartze's operation; the antrum and affected cells would be opened and drained, but the middle ear would be left alone.

3. The next indication is when there is actually acute mastoid disease in the course of chronic middle ear suppuration; this is a more definite state of affairs than the last. Pyrexia, pain, tenderness over the mastoid, anorexia, wasting, swelling of the deep meatal wall, or a swelling behind the ear pushing it forwards and downwards, in anyone suffering from chronic otorrhœa, calls for the complete operation. When you find that the patient has had a discharge from the ear for a long time, and that for the last few days or a week he has had pain in or swelling behind the ear, you are not dealing with an acute complication of an acute disease, such as a mastoid abscess in acute otitis media which antrectomy will probably cure, but with an acute complication of a chronic process. In such cases it used to be a common practice to simply open and drain the antrum. What happens? The sinus behind the ear gradually heals up, but the otorrhœa persists; the patient then goes to Ear Out-patients, and those who saw the first operation, but who do not follow his further progress, may make an incorrect mental record of the case as a complete cure, whereas it frequently happens, after a short trial of antiseptic treatment, that the patient is re-admitted, and the complete operation is performed; experience has shown that it is better to do this in such cases in the first instance.

4. I pointed out to you that the lining membrane of the meatus, middle ear and adjacent cavities is also the periosteum. If this lining membrane is diseased, the periosteum is no doubt always inflamed. One of the results of this is that new bone is formed; and in cases of prolonged suppuration it is not uncommon to see that the meatus is narrowed by projecting exostoses, or, more correctly, hyperostoses; they are the results of inflammatory thickening of the periosteum, and interfere with drainage, as well as with accurate inspection of the parts, and so treatment is handicapped. When these hyperostoses are present with chronic suppuration one can be almost certain that a complete mastoid operation is needed.

5. The next indication I have already drawn attention to, viz., when middle ear suppuration persists after antrectomy (Schwartze's operation). This is known by the Germans as an "after-operation," and I think it is a very good term.

6. The next indication is cholesteatoma. This is a high-sounding term for a condition which is rare in a typical well-marked degree, but of which, slight degrees are no doubt common. Formerly it was described by Virchow, Mikulicz, and others as a new growth affecting the temporal bone, but we now believe that cholesteatoma is always a sequela of middle ear suppuration, and it is recognised by the offensive nature of the discharge, which contains large yellow masses of epithelium and much pultaceous debris. These are masses of dead epithelium, which has been cast off from an ulcerating surface; the liquid portions of the discharge drain away easily through the meatus, the solid mass is retained, and as a result of its retention the mastoid process is absorbed until externally the cortex alone remains, while on the deep aspect, the dura mater, facial nerve or external semicircular canal may be laid bare.

If in the course of a radical mastoid operation the antrum and mastoid process are found to be excavated by cholesteatoma, this is easily removed with a sharp spoon exposing a smooth cavity lined by a shining epithelial layer known as the cholesteatomatous membrane or matrix, underneath which the bone is peculiarly smooth; but the cholesteatomatous membrane does not completely line the cavity, for if this be carefully inspected, there will be found somewhere a patch of granulations, and it is here that the gradual increase in the cholesteatoma is taking place by exfoliation of epithelium from the granulations, which in themselves indicate the existence of caries in the subjacent bone. As, therefore, cholesteatoma must mean caries of the bone, and as intracranial complications are common in association with it, operation is always desirable. This condition causes a good deal of intermittent pain, which is often relieved by the spontaneous discharge of a mass of this material through the external ear, sometimes as large as the terminal phalanx of the little finger; or deafness and pain may be relieved by its removal with a syringe or with forceps; these masses contain cholesterine crystals and bacteria, and have a peculiarly offensive odour.

7. The next indication is, to my mind, facial paralysis. This coming on in the course of chronic middle ear suppuration is an absolute indication for the complete mastoid operation. What does it mean? Either that the carious process has attacked the very thin wall of the Fallopian aqueduct, or that the disease is extending into the internal ear. The actual paralysis is usually directly due to the pressure

of granulation tissue, or inflammatory exudation on the nerve, and provided it is promptly relieved the paralysis will recover. In all the cases where this operation has been undertaken by me for the relief of facial paralysis, complete cure has resulted, even though several times it had been perilously deferred, and it is to me difficult to conceive any logical reason for deferring operation under such conditions, for it will be agreed that by the time inflammatory exudation or granulation tissue has reached the facial aqueduct, the opportunity of getting rid of its cause, the chronic middle ear suppuration, by means of antiseptics, has passed by.

8. The next indication is tuberculous disease. Tuberculous disease of the temporal bone is fairly common in small children: the last case seen at Ear Out-patients a few weeks ago was under a year old. It is generally recognised by a painless onset, enlarged cervical glands, and early facial paralysis. If you find a patient with enlarged glands and middle ear suppuration, suspect tuberculous disease. You might confuse them with the enlarged glands very common in patients who have middle ear suppuration and who have adenoids, but the glands affected in tuberculous disease are further back, well under the sternomastoid of the affected side. These babies soon get facial paralysis: I remember operating on two such cases one afternoon at the Evelina, and the outlook was not hopeful, because they both had facial paralysis and tuberculosis elsewhere.

In tuberculous disease of the temporal bone necrosis is frequently met with, and these sequestra are often of large size, and may involve the labyrinth, cochlea, or facial aqueduct. A temporal bone in my possession shows this tendency well, for in it, after an operation which consisted of little more than removal of sequestra and granulation tissue with a sharp spoon, the facial nerve, external semicircular canal, jugular bulb, and the first turn of the internal carotid are all laid bare. While less common in adults, it is followed by the same complications, and is intractable unless radically dealt with. It is interesting to note that direct extension to the meninges is most unusual.

9. At the onset of symptoms which indicate conditions favourable to the production of intracranial complications, *e.g.*, extension to the labyrinth suggested by nerve-deafness, vertigo, or constant tinnitus. It is worthy of note that gradual invasion of the semicircular canals may frequently be unassociated with vertigo, so that extensive erosion of the bony wall of the horizontal semicircular canal is often seen at operations when previously no symptoms have suggested its involvement.

10. The tenth and last indication for the complete mastoid operation is the onset of intracranial disease, when in all cases arising from the ear, this operation is undertaken both for the exact localisation of the lesion and as the primary route by which such a complication may be dealt with.

Mentioning only one of these complications, brain abscess, which often gives rise to difficulty in localisation, we know from Dr. Pitt's statistics, in his Goulstonian Lectures, of 1890, that disease of the middle ear and of the subjacent bone was the cause in one-third of his cases.

My last point, therefore, I cannot too strongly insist on, which is, that where there is intracranial disease, and you are satisfied the ear is the cause, you must carry out the complete mastoid operation, and use this as the route which will guide you to the abscess, sinus thrombosis, or whatever the lesion may be. What Surgeon at the present day, who regarded the appendix as the cause of a general peritonitis, would not make his wound so that he might first deal with the appendix, and so trace the lesion from its source in different directions? Similarly, one asks, why will some Surgeons, in brain abscess due to ear disease, continue to trephine the skull at the spot at which more or less indefinite symptoms suggest that the abscess may be? Yet Otologists have been telling them for more than ten years that that is not the right method. for post-mortem evidence shows that in over 90 per cent. of such cases a track of carious bone leads the operator directly from the primary focus in the temporal bone to the site of diseased dura with the subjacent abscess or infected sinus. (Körner, Die Otitischen Erkrankungen des Hirns, 1896.)

Practical Points in the Radical Mastoid Operation.

By the complete mastoid operation, I have told you we mean tympano-antrectomy. This was first carried out, almost simultaneously, in 1889 by Körner, Kuster, Zaufal and Stacke, who found that Schwartze's operation did not have satisfactory results in chronic cases. They removed the posterior meatal bony wall, so as to improve the drainage of the large bone cavity, and since then the operation has been abundantly modified. Shortly afterwards, Bergmann removed the outer attic wall, and various surgeons have given their names to plastic operations upon the posterior meatal wall, which serve the dual purpose of removing this

partition between the antrum and meatus, and of making use of its skin as a lining for the bone wound. The operation naturally divides itself into the following stages:

1. Skin incision and reflection of soft parts forwards.—A crescentic incision is made behind the ear. Some books recommend that it should be close to the ear, others at the margin of the hair; as a general rule I prefer a medium position. If you make it as far back as the hair line, the flap is too big and obscures one's view; whereas if it is too far forward there is a possibility of a permanent fistula behind the ear. The difference between those who recommend a big flap and myself may be due to the fact that they usually do not skin-graft the wound, whereas it is my custom to follow Ballance in this addition to the routine operation; and as skin-grafting is the most delicate and technically difficult part of the operation, those who omit it no doubt find that the incision farther back is no disadvantage.

2. Portions of the temporal bone and the external auditory meatus are now exposed. The postero-superior boundary of the external auditory meatus is seen to be interrupted by the projection downwards and forwards of the small process called Henle's spine, and running backwards above the external auditory meatus is seen the temporal ridge, which is continued forwards as the posterior root of the zygoma. What I show you in my diagram now is known as MacEwen's triangle; it is formed by (1) a tangent to the postero-superior margin of the external auditory meatus; (2) a vertical line drawn downwards through the most superficial part of the posterior margin of the external auditory meatus (from the actual margin of the meatus the bone is still convex outwards, and the tendency is to draw this line too far forwards); (3) the third side of the triangle is the temporal ridge. MacEwen's triangle is generally a very useful guide to the antrum, but the antrum may lie above its upper boundary, or the dura mater of the middle fossa may come below this line.

Another most valuable guide is the direction of the meatus, which has been to me of the greatest value. This varies considerably, for if the meatus goes straight inwards, you have to remove bone directly inwards; if it goes forwards you must incline your bone wound in the same direction. You may find you have a meatus which goes slightly upwards instead of directly inwards, and then the antrum is placed much higher than usual.

The next question is, How deep can you safely go? This is rather a difficult point on which to give practical information. In the course of the complete mastoid operation, after you have exposed Henle's spine and MacEwen's triangle, you will freely detach the skin and periosteum lining the roof and the posterior wall of the meatus. A probe or fine forceps introduced on to the inner wall of the middle ear will now give you its depth, and the depth of the antrum will be rather less than this. MacEwen's triangle gives the position of the antrum in one plane, and direction of the meatus and depth of the inner wall of the tympanum give help in other planes.

Finally, when in doubt, hug the upper boundary of MacEwen's triangle. There is no more valuable practical indication than this. I am pleased to see that Hunter Tod (Diseases of Ear, 1907) lays such stress upon this point that it is printed in italics, because it is exactly what experience has taught me. If you lose your bearings you can do no harm by keeping close to the temporal ridge, or even by removing it and the bone deep to it: free exposure of the dura mater in the middle fossa does not matter. Why extend your bone wound upwards? Because you cannot go downwards; it is by removing bone downwards that damage is done to the facial nerve. This nerve runs from before backwards, in a tunnel of bone on the inner tympanic wall, and then downwards, beneath the posterior meatal wall to the stylo-mastoid foramen. If you miss the aditus, and, working forwards, continue to remove bone towards the middle ear, you are very likely to divide the facial nerve. Turn your gouge with its back upwards towards the dura, and remove the bone towards the dura until the antrum is exposed.

The antrum is recognised (*a*) by its position, and (*b*) by the fact that a probe can be passed from it through the aditus into the tympanum. Its inner wall is now thoroughly exposed by removal of all edges of overhanging bone, and all adjacent or communicating mastoid cells are freely opened up and curetted. The possibility of exposing dura mater in enlarging the bone wound upwards has already been noted; similarly, the dura lining the posterior fossa and covering the bend of the lateral sinus may be exposed in working backwards. This sinus, which usually turns downwards two-fifths of an inch behind the posterior meatal margin, is especially likely to be placed unduly forwards on the right side, and though its dural covering is occasionally exposed, I have not known any harm result.

At this point Schwartze's operation, or antrectomy, as for acute mastoid infections has been carried out.

3. The third stage is to remove the bridge of bone external to the aditus, which is formed by the posterior meatal bony wall; by this, the antrum and the middle ear will be thrown into one cavity: the only danger in this proceeding is the risk of injury to the facial nerve. From the antrum, now freely opened, the aditus is seen leading forwards into the tympanum, and at the level of this gap the posterior meatal bony wall may be safely removed in the form of a wedge, using the gouge chiefly with its back towards the dura, when it will be well above the level of the nerve. A curved probe or pair of fine forceps may be introduced through the aditus to define it and to protect the facial, and for this purpose Stacke's guide was invented; of its value I can say nothing from personal experience, as it has always seemed to me an unnecessary instrument, and I have never used it. In making the lower cut in removing this wedge of bone, the gouge must be directed more horizontally, and it is well to complete the division of the bridge by sharp short cuts, with the gouge placed at the upper limit of the aditus. When the aditus is opened, the bridge below it is gradually shaved down so as to make a free communication between the antrum and meatus; the depth to which the bridge may safely be removed is well defined by a line first described by Dr. Hugh Jones, of Liverpool, in the Otol. Soc. Trans., vol. IV.; this line passes in the coronal plane, downwards and outwards from the inner wall of the aditus (where this is formed by the external semicircular canal) to the highest point of the floor of the external auditory meatus. As I show you in this diagram, such a line lies well outside the facial canal, and it has in my experience proved a guide of great practical value.

The risk of injury to the facial in this operation has been much overrated, for while, when exposed by disease, it may be accidentally bruised with the curette, such an injury often results in no paresis, even though twitching of the face has been seen at the operation. In the course of over 300 such operations here, I have never seen permanent damage to the nerve, and judging by the fact that while temporary paresis was occasionally seen among my early cases, yet for several years there has been no post-operative paresis of even a trivial degree, it will seem to be clear that the risk of such an injury solely depends upon anatomical knowledge, and is practically of little significance, as the course of the nerve is known to be absolutely constant.

4. The fourth stage consists in the removal of the outer attic wall, so that the attic cavity is well exposed, and now the malleus and incus, if not previously dislodged, can be removed.

5. The fifth stage is the formation of a skin flap from the soft parts forming the posterior meatal wall. In the method which I now follow, two cuts are made with a fine knife from the detached inner edge of the meatus outwards to its junction with the concha; the first is placed at the lowest point of the posterior margin, and the second at the junction of the roof and anterior wall. In making the former, the posterior auricular artery may be divided, but is easily secured, and the posterior flap having been thinned so as to consist only of skin, is sutured with a single catgut stitch to the deep aspect of the post-auricular flap. The tympanic cavity, attic and antrum are now carefully curetted, care being taken to avoid dislodgment of the stapes, when the whole cavity is packed for a few moments with wool soaked in adrenalin solution (1-1000).

6. Thin skin-grafts are taken from the arm by Thiersch's method, and carefully applied to the whole of the bone wound, which is closely inspected before their application, so that no blood may collect under them and interfere with their adhesion to the raw surface. This addition, introduced by Siebenmann in 1893, and modified by Mr. C. Ballance in 1900, I have for the past eighteen months carried out as part of the same operation as the radical mastoid, thereby avoiding a second anæsthetic.

7. The post-auricular wound is now completely sutured, except after operations for such conditions as brain abscess, in which drainage is necessary. You will see that I have made no mention of packing the bone cavity, and I have for about three years omitted this with no practical disadvantage or delay in healing, thus avoiding what used to be the only painful part of the after-treatment.

Change of Address.

Arthur W. Ormond, F.R.C.S. Eng,, from 37, Queen Anne Street, Cavendish Square, W., to 7, Devonshire Place, Upper Wimpole Street, W. Telephone 2610 Mayfair (unchanged).

W. Tuke-Johnson, M.R.C.S. Eng., L.R.C.P., from 24, Clive Avenue, to Orlebar Lodge, Lond Road, Twickenham.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Christmas Eve at Sea.

It is four o'clock, and afternoon is deepening into night. Lowering clouds hide from us what ought to have been a golden sunset, and a strong north-west wind sweeps across the deck, causing great angry waves to toss our boat to-and-fro like a tiny shuttlecock, and all this to the infinite discomfort of the unhappy passengers, to whom, for the time, she constitutes a prison.

We are a small party on board the S.S. "Minestra," which left Alexandria some days previously, and is now tossing on the waves in the Bay of Biscay. And we are not a lively party, be it added. Those of us who are not suffering from sea-sickness are suffering from home-sickness—most of us from a combination of the two—and a feeling of depression permeates the whole boat.

We are all of us very much alive to the fact that it is Christmas Eve, and we resent it. We are picturing to ourselves the scenes at home, the family gathering with its accompaniment of good cheer and good fellowship, and strive against it as we may, memories of past Christmases spent amidst brighter surroundings will obtrude themselves before our vision and refuse to be banished.

Envy and despair are uppermost in our minds to-day, and they show themselves in our low and drooping spirits, and gradually the general depression becomes a settled gloom. Huddled up in one corner, in an endeavour to find some shelter from the storm, sit two of the passengers confiding to one another with some detail the faults of another passenger. Their confidences are disturbed at intervals by two others who struggle wearily round and round the deck cherishing the vain delusion that they are "taking exercise." Backwards and forwards, up and down, to-and-fro, they wander like two lost souls in Hades, counting the number of rounds they make, each completed round of the deck giving them the satisfaction that they are a little nearer the end of their self-imposed task of walking a mile.

From the saloon come strains of Chopin's Funeral March, played with immense feeling on the ship's piano. We are all trying to divert our thoughts from the season of the year, and we attempt to deceive ourselves by thinking we succeed, but each one knows that he has miserably failed,

From one of the deck cabins emerges a young girl, who appears in public for the first time since the commencement of the voyage. Her manner suggests that it is only under compulsion that she appears now, and she makes no secret of the fact that her sole desire is to return to the cabin from whence she came. The silent passengers in the saloon eye her curiously, whilst some, with more feeling than tact, congratulate her on her re-appearance. The young lady, who sees no cause for congratulations at being forced from her berth, makes this known in a few plain words, and the occupants of the saloon relapse into silence again.

Presently a small boy, who has hitherto been in abnormally high spirits, disappears quickly with a bang of the door. A grim smile passes over the faces of some of those left behind, and the silence becomes almost painful.

After a time there is a request for more music, and the pianist of the "Funeral March" again seats himself at the piano. This time he selects some lighter airs, starting with the chorus, "Twenty love-sick maidens," from "Patience." The final "Ah, misery" is given by the doctor, who is stretched full length on a couch, and it is given with such feeling and expression that some of the passengers raise a half-hearted laugh, But the laughter sounds hollow and unreal, and echoes sadly through the saloon.

And another silence follows—a long tense silence.

It is broken by the cheery voice of the first officer outside, who is heard telling someone to "buck up." No one feels exactly like "bucking-up" and we resent his cheerful tones. It is for all the world as if some one had cracked jokes at a funeral. We feel that we should like to "go for" that officer, or rather see someone else do it, for we are hardly in the mood for doing anything of the kind ourselves.

The hours drag on slowly, and the hands of the clock point to seven. On the stroke of the hour an anæmic-looking steward appears, and, in a lachrymose voice, announces dinner. But the word means nothing to us. No one stirs, and the steward creeps quietly away like some tired ghost who has fulfilled his mission and fain would rest. We sigh wearily and listen to the clatter of knives and plates below, which inform us that a few hardy spirits are bravely struggling to do their duty. The sounds of crockery are mingled with the subdued hum of voices, and from time to time is heard the shrill voice of a lady telling the captain about her lately-deceased mother, who, during some rough weather at sea, fell down the hatchway and injured her head, the consequence of which, we gather, were not only painful but serious.

The meal finished, the captain enters with an imitatingly cheerful after-dinner smile, and in jocular tones offers us cigars. *Cigars!* If looks could kill, the "Minestra" would have completed her voyage under the command of the first mate. The small boy appears again. He is pale and nervous and fidgets in a corner. He remains for a few minutes, and then goes out with a tearful "Good night." No one answers him.

* * * *

Another hour passes, and we endeavour to rouse ourselves. We resolve to become Christmasy and seasonable in our behaviour, and begin by telling stories. One man tells us of the previous Christmas spent in Egypt under cloudless blue skies and an eastern sun. It sounds unreal and out of the picture, and we tell him so, whereupon he takes offence and refuses to speak again, Then another recites a ballad about a Christmas in the olden times. But the frequent allusions to holly and mistletoe, the Yule log and Christmas cheer, only serve to invite comparison with our present state. The ballad strikes us as altogether inappropriate and out of place, and a few discontented sighs take the place of the applause at

the finish, and the wretched man resumes his seat in disgrace.

The doctor, when called upon, chooses Shakespeare, and starts off with a speech from "Richard II":—

"Let's talk of graves, of worms and epitaphs."

This sounds more in keeping with our mood, and we nod a sympathetic approval. He gets as far as the line:

"For heaven's sake, let us sit upon the ground."

when we grow suspicious. To talk of "sitting on the ground" seems like mocking us in our trouble. We wish to hear no more, and he, too, is promptly voted a failure.

Next, we ask ourselves such original conundrums as to what would happen if one of the passengers went mad, or if the captain were washed overboard. No one is prepared with replies, and a sickly-looking individual volunteers a story. He proceeds to tell us of a wreck which happened on just such a night as this. He enters into minute details with regard to the sufferings of the passengers, who took to the boats and were tossed about for days on the open sea, and relates how, one by one, they drank salt water for want of fresh, and thereupon went mad and threw themselves overboard.

This cheerful narrative proves too much for the nerves of some of those present, and in the general gloom which succeeds it, the majority slink silently to their berths.

* * * *

Midnight approaches, and the remaining few of us, who prefer any place to our cabins, crawl out on to the deck, while eight bells are sounded, and we watch the second officer, wrapped in tarpaulins, go up to relieve his comrade on the bridge. The rain has ceased, but the waves are lashing the boat with increased fury, and we cling to the rail with our hands, while our teeth chatter a mournful accompaniment to the storm.

Twelve o'clock! It is Christmas morning, and in imagination we hear the merry peals at home welcoming another Christmas Day. From long-hallowed custom we wish each other "A Merry Christmas," and then we smile grimly at the irony of our wishes.—A Merry Christmas!

It is the last straw, and we steal away silently to our berths, but as we vainly try and snatch a little sleep we murmur that the sea was made for fishes, and we vow we will never go to sea again.

But all this was a year ago. N. H. O.

Papers by Guy's Men.

The Radical Cure of Complete Procidentia of the Uterus, with an Account of a new Method of Operation for this Condition (Illustrated). By Lawrie M'Gavin, F.R.C.S. Eng.—*The Practitioner* for December, 1908.

Three Lectures on the Pathology and Treatment of Diabetes Mellitus, viewed by the Light of Present-day Knowledge. Delivered before the Royal College of Physicians of London. Lecture III. By F. W. Pavy, M.D. Lond., LL.D. Glasg., F.R.S.—*The Lancet*, December 12th, 1908.

Guy's Hospital Dental Society.

A meeting of the Dental Society was held on Friday, December 11th, the President, Mr. J. E. Spiller in the chair. The following casual communications were presented:—

Mr. W. Archer Hodgson,

(*a*) Specimen of Polypus of Pulp.

(*b*) Model showing supernumerary tooth in a central incisor region (upper jaw.)

Mr. Bradman,

Denture made in bone, with natural teeth mounted on it.

The President then called on Mr. W. A. Hodgson to read his paper on "The Dental Pulp."

The paper was mainly devoted to a careful consideration of the condition under which devitalization of the pulp should or should not be performed.

Mr. Hodgson advocated the saving of the pulp in a much larger percentage of cases than is at present done.

In the discussion which followed, the President, with several members, took part, and many valuable points in the treatment of various pathological conditions of the pulp were brought forward.

The following cases are of interest:—

Case I.—J. R., æt. 33, presented himself at Dental Out-patients on Tuesday, November 10th. He had a large pedunculated growth between the upper left central and lateral incisor teeth extending nearly to the cutting edge. This growth was reddish, bled freely, and was not very tender to touch. On Tuesday, November 17th, patient was anæsthetized with nitrous oxide administered by the nose; the central and lateral incisor teeth were removed, then a pair of laminectomy forceps (bone forceps shaped like a pair of dental bayonet forceps) were put into the sockets, and the alveolar process cut through on each side, the epulis then being cut off at the base with a pair of Lane's gouge forceps. On microscopical examination, the tumour presented the ordinary characters of a fibrous epulis.

Case II.—M. S., æt. 21. Patient came up on Saturday, November 7th, with a small growth, the size of a pea, between the upper right canine and first premolar. This also was of a purplish red colour, and bled freely, but was not very sensitive. A local anæsthetic, Novocaine gr. ½, was injected, an elliptical incision made round the growth with a Daly's knife; then with an ordinary enamel chisel and riveting hammer, its attachment to the bone, and as much of the septum between canine premolar as could be got at, was chiselled away, the base being afterwards cauterised with liquefied carbolic acid, 90 per cent. In using an ordinary Daly's knife and enamel chisel in this way it is of course essential that they should be thoroughly sterilized before use.

The next day the teeth on either side were rather periostitic, but otherwise all right, and no trouble has been experienced with them since. This epulis, on microscopical examination of a section stained with magenta, showed some elastic fibres; these were not present in the other case.

Keats and other Folk.*

IN "An Alabama Student," DR. OSLER has collected together a number of essays and addresses which he has delivered before various collegiate associations. They are addresses and essays of the kind that is published in college magazines, and after reading through them, one wonders why they have been thought worthy of a cloth binding, and the excellent paper and type of the Clarendon Press. Certainly not because they are likely to become classics. Loosely written, in a style that makes no pretence to being pure, and showing on nearly every page evidence of the handiwork of the literary tyro, they are not masterpieces. But they are informative, and, after all, Edward Dekker is not far wrong when he says that the man who tells something that is worth the telling, deserves better of our praise than the fellow who writes finely on nothings.

I am not here concerned with Dr. Osler's style as a literary artist—if he claims to be one. We of the medical profession are so accustomed to bad writing and worse style, that the easy fluency of the Regius Professor of Physic has come to be looked upon by many of us as excellent. But in these essays there is much that clashes. Dr. Osler is too fond of quotations, and he does not possess the skill of Charles Lamb or Saint-Beuve, to "quote with relish and adorn with piquancy." He quotes, on occasion, with astonishing foolishness, and misquotes with irritating frequency. I should have thought even a Regius Professor of Oxford knew the Lost Leader, and the difference between a model and a pattern!

To Guy's men, the article on Keats will naturally prove most alluring, but it is a disappointment. Dr. Osler has given us nothing new; he has not even put the old in a feast-day dress. The essay is a series of extracts, baldly written in the style of a chapter in the text-book. As if a Poet were not infinitely above a Paralysis, and Junkets of vaster importance than Jaborandi!

The redeeming feature in this, as in all the other essays, is the sympathetic treatment of the subject. The author shows his good will towards the men whose biographer he attempts to be. Here and there it is a good will tempered by a desire to criticise with a judgment that is not always just, and an incapacity to see matters from a broader level than that which a professional man is inclined to take. It is in this spirit that Dr. Osler went hunting through the Keats poems and correspondence, expecting to find that the greatest Guy's man had been inartistic enough to enshrine Surgeon Lucas in the "Endymion," or to introduce blood-letting and clystering into the Nightingale Ode. For I do not know how else to take his remark, that there is nothing in the poems to show that Keats had been influenced by his professional work and life. For myself, as I have attempted to prove elsewhere, almost every poem, and many of the letters, show that this work and life have not been ineffective upon Keats' literary career. It is a point on which each of us may hold his own opinion, and be none the worse for holding a wrong one.

My complaint against Dr. Osler's essay on Keats is that it is too unequal, too amateurish to be called an essay in a true sense. It looks upon the poet in an encyclopædist's manner. Its author seems everlastingly to be trying to solve the riddle of the porridge pot. Does it matter? This, that, and the other, do they matter one iota or the lisp of a *spiritus lenis*? To some of us Keats is very much alive—a friend to hold communion with, unmindful of the fact that he was only an apothecary, heedless of it even. We love him in spite of the fact that he was a doctor; some of us feel sure that had he lived to-day he would not have joined the B.M.A., or handed in his name to Mr. Paget's Society. We object to his dissection by those who admire an Alabama student, a Louis, or a Pepper just as much as they tell us they do Keats.

Leaving him, I have but little to say of the other essays; they are informative—some very much so. Dr. Osler is in his element when he deals with purely professional subjects, and quite out of it when it comes to purely literary matters, as in the essays on Frascatorius and Browne. The latter is a reprint of the lecture before the Physical Society three years ago, and gives nothing that has not been said before, and said much better, by other critics. But it is scarcely a criticism; it is an appreciation. Dr. Osler is everywhere enthusiastic—red-hot. That is the best thing about his work; it inspires the reader with a feeling that the man who wrote this, felt this, and would have you feel it. And that, after all, is great praise. Enthusiasm is a rare quality in writing nowadays. The journalist knows it is a dangerous quality to possess, and the literary critic has long since thrown it overboard. Therefore, it is refreshing to find it in these essays, and it does not appear to have exploded the ship that carries Dr. Osler's literary treasures. Rather it has helped the voyage onward. Such essays as those on the exploiter of Alexis St. Martin and on Bartlett are admirable, and will well repay reading.

* *An Alabama Student, and other Essays.* By WM. OSLER, M.D., F.R.C.P., Clarendon Press, Oxford. Cloth. 8vo. 7s. 6d. net.

Guy's Musical Society.

This society, now in its fourteenth season, gave a concert on Tuesday, December 15th, under the capable direction of Mr. Henry Taylor, and before a fairly good audience.

The programme opened with the singing, by the chorus, of Costa's version of the National Anthem, which we consider would have been more appropriate at the end of the concert. The tenors and basses then sang Byrd's solemn and dignified canon, "Non nobis, Domine! non nobis, Sed Nomini Tuo da gloriam!" Sister Theresa gave a contralto song, "A May Morning," (Denza), and Nurse Gill, who has a sweet, if somewhat small, voice, sang "The Children's Bower" (Cristabel), but her enunciation was imperfect. Two part songs, "O Peaceful Night!" (Edward German), and "Lullaby of Life" (H. Leslie), were sung by the chorus, the latter in much better style than the former. Mr. W. S. Kidd then contributed two of those little amorous songs which suit his voice so well, "The Slighted Swain," and "The Pretty Creature," by H. Lane Wilson. Two part songs for male voices followed: several of the lady members, we noticed, stood up, as though anxious to sing. The part songs were two of Mendelssohn's, "Slumber, Dearest," and "Vintage Song," of which the first was unaccompanied. The latter was probably the most appreciated item in the first half.

Nurse Mather gained much applause by her dramatic rendering of the "Love Song of Har Dyal" (Batten); she has a good clear soprano voice, which would be much improved by more attention to colour and expression. Another part song, "Daybreak," by Eaton Fanning, which was omitted on the programme, and Schumann's cantata, "Song of Night," which was very well interpreted by the whole chorus, the ladies especially deserving great praise, concluded the first part.

The better half of the concert was Part II., when "The Erl-King's Daughter," by Niels W. Gade was performed. This ballad, founded on Danish legends, besides being typically Scandinavian, is highly dramatic in conception, and at times has something of the fire and spirit of Schubert's well-known song on the same mythological personage. The work is arranged for a chorus and three solo parts; that of the Mother (mezzo-soprano) was taken by Nurse Miller, who put just the right dramatic quality into her singing; so also did Mr. L. C. D. Irvine, in the part of Sir Oluf (baritone). Mr. Irvine's fine voice and training will be very valuable to the musical circle at the hospital. Nurse Foxon took the part of the Erl-King's daughter (soprano), and sang well, but hardly put enough *verve* into her performance. The choruses, except for two noticeable failures in attack, were well sung, but gave the impression that the society could do still better after more frequent rehearsals. Sister Ethel, at the piano, and Mr. Leigh, at the organ, supplied the accompaniment to the cantata, and probably played under difficulties; at any rate, it cannot be said that the two instruments blended as well as had been expected. Quite a small string band would have sustained the vocalists much more efficiently, and interpreted the alternately mystic and martial qualities of the music much better. On the whole, however, the performance of the "Erl-King's Daughter," which we believe is a more ambitious work than the society has been accustomed to undertake, reflects great credit on all concerned.

It has been mentioned that the well-known and respected Mr. Henry Taylor conducted; it remains only to add that Sister Ethel filled the important post of accompanist to the great satisfaction of all, and that the arrangements of the concert were carried out very efficiently by the energetic secretary, Mr. Douglas Mitchell, who is to be congratulated on its success.

Pupils' Physical Society.

A meeting of this society was held on Saturday, December 12th, in the Wills Library, Mr. W. W. Cook in the chair. The following clinical cases were shown and evoked considerable discussion, in which Messrs. Rankine, Ticehurst, Digby, Palmer, Perkins, M. M. Adams, Layton, S. Price, B. H. Palmer, Rahman, Mitchell, Trethowan, Schulenberg, and the Hon. Secretaries took part.

1. Primary muscular atrophy	Mr. Townrow.
2. A case of proptosis	Mr. Rahman.
3. Epithelioma of tongue	Mr. Sanford.
4. Epithelioma of auricle	
5. Tumour of upper jaw	
6. Hæmophilic knee-joint	

Pass List.

University of Cambridge, December, 1908.—Degree of M.B. conferred: C. H. Rippmann.

Royal College of Surgeons of England, December, 1908.—Final Examination for the Fellowship: B. Glendining, W. Welchman.

Papers by Guy's Men.

Case of Aseptic Cavernous Sinus Thrombosis. By H. W. Pigeon, M.C. Cantab., F.R.C.S. Eng.—*British Medical Journal*, 12th December, 1908.

A Simple Method of Obtaining a Preparation of Living Isolated Leucocytes. By Constant W. Ponder, M.A., M.B., B.C. Cantab., L.R.C.P. Lond., M.R.C.S.—*The Lancet*, 12th December, 1908.

An Epidemic of Influenza Characterized by Œdema of the Eyelids. By N. I. Spriggs, M.D. Lond., F.R.C.S. Eng.—*The British Medical Journal*, 12th December, 1908.

An Address on Some Difficulties in Diagnosis and Treatment of Cases of Suppuration in the Neighbourhood of the Diaphragm (Illustrated). By W. Hale White, M.D. Lond., F.R.C.P. Lond.—*Ibid.*

Reviews, etc.

The price of books submitted for review should in every case be stated.

Diet in Infancy. By A. Dingwall Fordyce, M.D., F.R.C.P. (William Green & Sons.) Price 3s. 6d. net.

This little book should form an extremely useful addition to the library of all members of the medical profession, and particularly of general practitioners. The division into sections is somewhat confusing and disjointed at first sight, but they certainly economise space and make reference easier, The reference to fæces examination is excellent. The table of infants' foods is very useful, especially the remarks appended to each. The appendix dealing with the tuberculin test especially should afford much useful information and advice to country practitioners, but the section on infantile diarrhœa, considering its importance, appears to us somewhat abbreviated.

Altogether the book is a very valuable reference book for a busy practitioner to have handy.

First Lines in Dispensing. By E. W. Lucas, F.I.C., F.C.S. (Messrs. J. & A. Churchill). Price 3s. 6d. net.

This little book is written as an introduction to dispensing for those whose calling sometimes necessitates an elementary knowledge of the subject. Medical men in practice, who do their own dispensing, will find the time taken to read through it well repaid. Many a nurse, who may find herself in remote hospitals in this country, or in the colonies, will be glad to have a small book (not too technical) which describes the manipulative details of practical dispensing, To such, this book will be of great value. Clear directions are given for dispensing mixtures, pills, cachets, etc., of the usual types. A list of Latin terms commonly used in prescriptions is given, percentage solutions are explained, the requirements of the Pharmacy Acts are briefly dealt with, and the antidotes to the common poisons tabulated.

We have received from Messrs. Burroughs, Wellcome and Co, a copy of their *Photographic Exposure Record and Diary* for 1909. This pocket-book, with its artistic green cover, simple exposure calculator, and compendium of useful information, is probably by this time known and valued by all amateur photographers, but it may be pointed out that it forms a most acceptable little Christmas or New Year gift to all who make the camera one of their hobbies. The 1909 edition has all the familiar features of previous issues, and has as its frontispiece a striking view of "a November night in Trafalgar Square." We have much pleasure in adding our share to the general chorus of welcome which greets the annual re-appearance of this photographic pocket-book.

Miller Fund.

Dr. O. Marriott	...	...	...	...	£1	0	0

Sport.

Rugby Football.

LONDON WELSH v. GUY'S HOSPITAL.

Played at West Ham on Wednesday, December 17th, under conditions about as doleful and dispiriting as possible. In the first place, "Captain" Stringer had great difficulty in getting a team together, exams. accounting for some absentees, and various excuses being advanced by others. Stringer himself had a bad cold, and was really more fit for bed than play. However, the side that eventually did represent the hospital were all but successful, although the Welsh had the assistance of one or two outside men who strengthened the side, the most notable additions being Larcombe, the Somerset half-back, and Williamson, the London Irish forward. The ground was very much on the soft side, so that accurate handling was almost out of the question. Still, one or two good bouts of passing took place, but no one was able to swerve without finding earth, except Maddocks, and even he once or twice slipped up most disconcertingly.

Almost as soon as play commenced Stokes missed a fairly easy penalty, but one must remember that the ball was as slippery as glass. Just afterwards the same player made a great attempt at goaling a try gained by Tooth. Medlock tried a drop at goal; luckily the ball went wide, and Tooth, gathering nicely, scored rather far from the posts. The home side did more pressing after this reverse, and, though the game was chiefly confined to the forwards, Maddocks at length secured and dodged in by the posts. Evans had hard luck with the kick, the ball hitting the upright and rebounding the wrong side.

On change of ends, the London Welsh had much more of the game, and for quite two-thirds of this half they were attacking. Once or twice only Guy's got away. The Welsh adopted the high kick and quick follow up, and this plan answered well, the ball being very difficult to handle or field safely, and twice J. F. Williams gained tries, which Evans missed goaling. At length, with "time" fast drawing on, Stokes gained ground with a lengthy kick, and some nice passing resulted in Tooth again scoring a try, too wide for the extra points to be added. Just before the final whistle Glendining made a good attempt at dropping a goal, but the ball sailed just a yard wide, and London Welsh thus won by 9 points to 6.

Team :—

GUY'S.—V. Glendining (back); L. B. Stringer, F. Tooth, G. E. W. Lacey, L. Stokes (three-quarters); A. H. Medlock, P. J. Monaghan (halves); H. R. Mullins, H. Hoby, W. S. Stranach, C. S. L. Roberts, E. L. Elliott, T. D. Stout, H. R. Danby, F. A. Lowe (forwards).

Referee: Mr. E. F. Walker,

REMARKS.—The forwards played well, especially in the loose, but there was not so much "shove" in the scrum as usual. Medlock was very good in attack, but Monaghan was better defending. Tooth made a very

creditable *debut*, and the other threes were sound, while Glendining played a safe game.

GUY'S v. BEDFORD.

With this match, played and won at the home ground last Saturday, December 19th, Guy's bring the first half of their season to a close with a total of 8 matches won, 5 lost and 1 drawn, or 164 points to 107. At this time last year, if one may for a moment compare, Guy's had 139 points to 39 in their favour, and their line had only been crossed on seven occasions, the other points being given to opposing sides through penalty goals. The disparity between the totals of last year and this suggests to the casual observer that this year's team is not up to the standard of last, but this is not so. As one who has watched every game except Newton Abbot and Northampton, I am confident that this year's team when at full strength will prove a much more formidable one than last year's. For reasons too many and varied to go into now, Guy's have only on one or two occasions been fully represented, and when the side get their best men out, and play them together regularly, a tremendous improvement will ensue, and it will be disappointing if the present Cup Holders still retain the trophy, when Guy's meet them with a full team, fit and able.

This match under notice found Guy's again below strength. Archer was away at Northampton, Hind, Jones, and Saner resting, and Moberley on the injured list. Still, the team played a good game, and won handsomely by 18 points to nil. It must, however, be stated that Bedford had their best three-quarters, Heard and Gompertz, on the injured list, Nailer, another good man, away, and Franklin, from the pack, was playing at Northampton. Guy's had the best of the game throughout, and Bedford never looked like scoring from kick-off till final whistle. The home forwards, well led by Mullins, got the ball in the scrums, and overran the opposing pack in the loose. Monaghan and Medlock were much better than Hemsley and Cocking, so that the Guy's quartette had the ball constantly. The first score, however, came from the forwards, Mullins getting a try in some close work on the line, and Stokes kicking a good goal. A little later, the home halves and threes handled accurately, and Lee passed judiciously wide out to Stokes, who landed a try, close by the posts, and himself converted More passing, after the kick-off, and the ball once more was worked across for Stokes to gain an unconverted try by the flag.

After half-time, Bedford once or twice got over the half-way line, but I do not think they ever reached the home "25." Lee put in some fine fielding and tackling; Glendining also did some neat work at full back, and Lacey gave sound assistance.

Guy's were soon on the aggressive again; some very smart work among the front rank men, of whom Roberts and Stranach were most prominent, kept play close to the Bedford line, and Stringer had very hard luck on several occasions. The slippery ball was difficult to manipulate, and passes came badly, but one lovely run and pass to Stokes was almost ending in a try. All along the line, Guy's delivered an attack which, about ten minutes before the end, saw Roberts touch down for a try, and a very fine kick by Stokes converted the effort. Foot-hold in the mud was difficult, but both sides played gamely till the long whistle found the scores, Guy's 3 goals 1 try (18 points). Bedford, nil. Team:—

Guy's.—V. Glendining (back); L. B. Stringer, H. Lee, G. E. W. Lacey, L. Stokes (three-quarters); A. H. Medlock, P. J. Monaghan (halves); H. R. Mullins, A. H. Crook, H. Hoby, W. S. Stranach, C. S. L. Roberts, C. G. Sprague, T. D. Stout, A. Seabrook (forwards).

Remarks.—The forwards played, as usual, splendidly. Guy's have seldom had so many good forwards at their command. Medlock was distinctly good, and Monaghan, except for some erratic passing, was useful. All the three-quarters were in good form, and their passing, with a ball in a most slippery condition, reached a high standard. Glendining did the little that came his way confidently.

From the Gazette's Special Pathologist.

R., Ramsgate.—This growth is a squamous-celled epithelioma in which there are ingrowing epithelial columns with cell nests. It is somewhat atypical.

G.M.J., Alton.—No tubercle bacilli are detected in this specimen, which contains a few small patches of muco-pus.

W.S., Southsea. — *Reaction*, acid. *Sp. gr.*, 1010. *Albumen*, a considerable amount. *Blood*, vide infra. *Sugar*, absent. Microscopical examination of the centrifugalised deposit:—The large amount of blood, the corpuscles of which constitute the deposit from this urine, is not associated with any pus, and no crystals or tube casts have been found. There are to be seen a few minute clumps of epithelium, possibly of prostatic origin, but no growth cells or fragments are distinguishable. Bacteria are fairly abundant, but, as the urine must be stale, they are most probably entirely adventitious. A specimen should be sent at a time when there is less hæmorrhage, because urine containing so much blood is of little use for examination.

C.D.P.S., Huddersfield.—No tubercle bacilli are detected in specially stained preparations taken from the centrifugalised deposit of this urine. Are we to proceed to inoculation methods? We should require another catheter specimen for this purpose. This specimen contains tiny cocci, and will not keep for a reply.

PATHOLOGIST.

Birth.

ALEXANDER.—On November 8th, 1908, at Cambridge, Cape Colony, the wife of Dr. K. B. Alexander, of a son.

Ed.—A. N. C.

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